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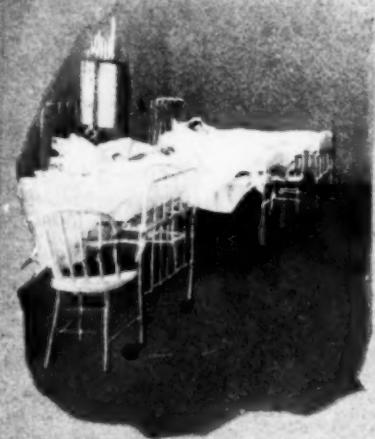
December 1926

No. 6

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXVII

December 1926

No. 6

BRINGING THE SPIRIT OF CHRISTMAS TO THE HOSPITAL

WHAT a pity to spend Christmas in the hospital."

How frequently we hear that ejaculation from people who picture their friends and relatives, who happen to be hospital patients, in the gloomy, uninviting institutional place that the hospital once was. But people who have actually spent Christmas in the modern hospital express quite the opposite thought and rather say, "You can't imagine how happy and homelike Christmas can be in the hospital."

The coming of Christmas each year brings to people of all creeds and of all climes the same message of mingled reverence and joy, and surely, by its very humanitarian nature, the hospital lends itself, probably more than any institution except the home or the church, to a Christmas observance that rings a note of true spirituality and

the belief in the eternal. Because of this, hospital superintendents everywhere have caught the contagion of the season and seize their opportunity for fulfilling that first Christmas message of "Peace on Earth Good Will to Men," by doing all that can be done to bring not only physical relief but joy and happiness to suffering humanity.

Surely the movement in recent years to bring the home atmosphere to the hospital has no greater expression than in the hospital's Christmas activities throughout the entire country.

As one superintendent so aptly expresses it, "To all entrusted with the care of both old and young who are deprived of the privilege of spending this day of all days about their own firesides rests a responsibility that can well be turned into pleasure for all, and it is for those in responsible positions in our many institutions to instill into the



Christmas Eve at Grasslands Hospital, Valhalla, N. Y.

minds of everyone the spirit upon which depends the happiness of all who are unfortunate enough to be our guests at Christmas."

One cannot visit a hospital at this time without being impressed by the decorations of the wards and of the children's departments, without realizing the hours after the day's work has been done that have been spent by the nurses, social workers, dietitians and other personnel of the institution in making the rooms, wards and corridors bespeak the atmosphere of Christmas to bring joy particularly to the children and ward patients. Women's and junior auxiliaries give most generously of their time and energy to procuring



THE HARTFORD HOSPITAL

WISHES YOU

A MERRY CHRISTMAS
AND A SPEEDY RECOVERY

A greeting card similar to this is presented by the Hartford Hospital, Hartford, Conn., with the gifts to ward patients and on the trays of private patients.

and preparing gifts to make the patients happy.

In addition to decorating the hospital, to wrapping up numerous bundles of cheer for every patient, to preparing extra "goodies" to make Christmas dinner really homelike, the personnel of many hospitals and often the patients of the chronic hospitals and those for the mentally ill spend a great deal of time and effort in preparing Christmas programs and in other social activities. Indeed, the celebrations in some of the mental hospitals vie with churches and schools in the elaborate programs and parties which they present.

It has become almost a universal tradition for the nurses, both graduate and undergraduate, to bring the spirit of Christmas to the hospital by marching through the corridors of the hospital early Christmas Morn with lighted tapers, singing the first Christmas message that came from the shepherds at Bethlehem almost 2000 years ago.

It is impossible here to describe the variety of ways in which Christmas is celebrated in different hospitals and only a brief sketch can be given of the celebrations in some general, children's and mental hospitals as typical of how Christmas is observed in the various types of institutions.

That patients, even the poorest of them in the

charity wards, in the large municipal hospitals have a merry Christmas and that the majority of hospitals are doing everything to promote the happiness of their patients and employees is testified in the following vivid picture of Christmas in one of the large eastern hospitals.

* * * *

Christmas! What a wealth of happy memories the mere word conjures up. But what can it mean to hospital patients, particularly those in a city hospital, many of whom are quite forgotten by their friends outside the hospital. Nevertheless, the thousand odd patients who spent last Christmas in one of the municipal hospitals of an eastern city have good reason to remember the joy and happiness the day brought.

Weeks before Christmas it began to be whispered about that each of the patients would be asked what he or she wanted for a gift, and the thing each one asked for would, if possible, be given them.

Then it is announced that on a certain day a messenger will come to list the gifts that the patients have finally decided upon. The day when he comes is almost as wonderful as Christmas, for really to tell someone what you want for Christmas with the expectation of getting it, is a startlingly new experience for many of our patients. The joy of anticipation makes the intervening days until Christmas happy ones.

Package for Each Patient

Christmas day finally comes and the many things that have been done to give the wards a festive appearance, are overshadowed by the fact that a package gay with Christmas ribbons is at each patient's bedside, and the package always contains the very thing the patient has wanted, even though many of the patients have been admitted after the visit of the Christmas messenger. Fruit, candy and gay cards always accompany the gift, provided such things are not forbidden. And even on Christmas Day many prohibitions are temporarily released.

When the morning toilets are completed, the new articles of clothing make a gay showing, and those who doubt that clothes contribute to morale, would have their doubts dispelled if they could see the effect that clothes have, even on patients whose days are numbered. Some do not choose practical gifts and many who think they know all about the "sick poor" found in our city hospitals have many surprises in store. It is almost unbelievable that even when death is just around the corner, almost in sight, patients can be gay and reckless as well as pathetically unselfish.

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The children's ward was gayest of all, for instead of the drab sameness of hospital clothes, that make it difficult at times to distinguish them, each child had a different style of dress of a color that matched his or her eyes, and the girls had bright hair ribbons, and all had toys of all descriptions.

All this means work, much money and a certain kind of courage and perseverance that is not dismayed by a Christmas list containing such items as artificial limbs, false teeth and wigs. A generous woman who prefers to remain anonymous has for years dispensed her gifts in this

given tea and sugar, on account of this festival."

So reads the entry for Christmas Day, 1789, on the records of the Philadelphia Hospital and Almshouse. There was no mention of Christmas in any of the preceding days' records nor the days following. How different from the Christmas in the successor of that institution, the Philadelphia General Hospital, one hundred and thirty-six years later, in 1925.

Preparations for Christmas began at least one month ahead. First, there was the head nurses' meeting, when head nurses and dietitians planned that the Philadelphia General Hospital should



A view of one of the wards of the Hartford Hospital during the Christmas holidays.

quiet way. And thus all who help with the work that all these presents entail, count it a privilege.

* * * *

How Christmas is spent in a large city hospital is most interestingly told by Stella Goostray, R.N., educational director of the school of nursing, Philadelphia General Hospital, Philadelphia, one of the largest city hospitals in the country.

* * *

"Friday, 25, being Christmas day the people were not kept at work but were allow'd full rations of meat with some extra allowance of suet for dumplins or a kind of boil'd puddin and also had a quart of 4 penny beer served to each man and a pint to every woman who were likewise all

have the finest Christmas dinner in its history. The chief concern was how to get ninety-five, more or less, carving forks and knives for that auspicious occasion.

Meanwhile, letters came in from all over the city. "What can we do for your patients?" The women's advisory council of the hospital and the cooperative club, an organization made up of a large number of women's clubs especially interested in the patients of the Philadelphia General Hospital, were on tiptoe. Each club adopted a ward, and weeks previous to Christmas were planning things filled with loving thoughts for those patients.

In the interns' building, some of the interns

were preparing to be Santa Claus on the children's ward. In the occupational therapy shop men and women were finding joy, and sometimes healing, in fashioning gaily colored balls and shining silver icicles. In the last few days before Christmas the school of nursing office began to look like the toy department of John Wanamaker's.

The diet kitchen had become a great warehouse. Imagine having an avalanche of six tons of candy, eighteen hundred pounds of turkey and seven bushels of cranberries loaded upon you. Truck loads of evergreens and holly appeared. But there was no bustle or commotion. The sick patients were cared for just as at other times. The nurses went quietly about their work. They walked through the long bare corridor and perhaps an hour later came back to find it transformed with garlands of evergreen. Then, into each ward came a great towering spruce tree, erect and stalwart, as if it, too, felt the privilege of having a share in these festivities.

Eighteen Hundred Boxes to Fill

Orderlies, attendants, nurses, and interns all set to work to trim the trees. Over in the diet kitchen eighteen hundred boxes had to be filled with candy, raisins and nuts. Homesick probationers are just the best people in the world for this particular job. They were much too interested in getting the boxes filled to stop to eat the candy. Hundreds of stockings were crammed full, a sprig of holly was fastened to each bed and the presents were all chosen and labeled with names, for there was no hit or miss distribution of gifts.

For weeks Santa Claus's sub-station in the school of nursing office had been working overtime, and when Sammy wrote a letter asking for a "train of cars with an injun" that request was duly noted. However, Sammy did more than make his request. He was thoughtful of Santa Claus' purse. He enclosed a clipping from the newspaper with an advertisement featuring this particular toy at reduced prices.

But the kiddies were not alone in their requests. Albert, who has been on men's nervous ward for forty years, always wants a mouth organ. The motion of his arms is so limited that the mouth organ has to be mounted on a stick. The sweet-faced little old lady, with an orthopedic condition, needed a little shawl to keep her shoulders warm. And Santa Claus kept faith with all of them.

Who wouldn't be a night nurse on a children's ward on Christmas Eve, stealthily passing from bed to bed, hanging on each a fat red stocking, hardly daring to breathe lest Johnny's slumbers be disturbed and he remark, "Didn't I tell ye there ain't no Santa Claus?"

Christmas Day festivities begin early in the morning at the Philadelphia General Hospital. The Christmas light barely streaked the Eastern sky, when the student nurses' glee club gathered by the superintendent of nurses' door and, softly singing, greeted her with a carol. Her door opened and she answered with a "Merry Christmas." Four groups of nurses organized so that all departments of the hospital could be speedily and conveniently visited by the singers.

Santa Claus paid a visit to the wards soon after nine o'clock. The children were both frightened and delighted at the same time, and even the old men and women looked forward to his coming.

The crowning surprise for the patients came when nurses and interns gathered each ward-family around a banquet table and a real roast turkey, with all the trimmings, was carved before their very eyes by the intern. Never was a Christmas dinner more enjoyed. Never was a Christmas turkey more talked about for days and days. Those patients who had to stay in bed, had a tray covered with a Christmas napkin and each one had a card bearing his name and a Christmas greeting. While the dinner was being served the director of public health, the medical director of the hospital, and the superintendent of nurses visited each ward and extended their personal Christmas greetings to the patients.

Dinner did not end the festivities. In one corridor an orderly did the "Buck and Wing," while the wheel-chair patients sang and kept time by clapping their hands. Elsewhere, a new victrola or a new radio brought Christmas music, or a group of musicians gave a concert. Thus the day closed with everybody tired and happy.

Annual Vaudeville Staged

However, over night the Christmas spirit gathered fresh enthusiasm for the week. Every night the student nurses assembled in the quadrangle and sang carols. Every day a ward had a party, and finally came the annual "big party" which had its origin over forty years ago. One of the treasures of the school of nursing is a letter written by Alice Fisher, the founder of the school, dated Dec. 4, 1886, to a lady in Philadelphia, in which Miss Fisher told of the plan of "giving an entertainment to the patients in this hospital during Christmas week." That entertainment has been given each year since, and one of the ladies who helped at the entertainment in 1886 was present at the one given in 1925. Every patient who could possibly be moved was taken to the amphitheatre, from the tiny pickanniny, who had been delighting numerous audiences with the Charleston, to the old patients who had grown grey within these

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walls, and the world of pain was forgotten in laughter and music because somebody outside remembered.

* * * *

Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., presents an apt characterization of Christmas in his 600-bed general hospital.

* * * *

The coming of Christmas each year brings to all climes and people the same message—one mingled with reverence and delight. Probably no other day has ever been so sacred and so universally observed and its observance through all these centuries has brought to us each year its contribution of evidence that supports our belief in the eternal and it means delight to millions of childish minds that are wrapt up in its mythical significance.

With this thought in view, preparations at the Hartford Hospital begin many days before Christ-

mas, and especial planning is made for the little ones, who will be with us at that time.

Every ward, of which there are sixteen, has its beautifully decorated and lighted tree; every window its wreath.

Santa Claus, with a bountiful supply of gifts and toys, visits every child and makes him forget his whereabouts. Every ward patient is presented with three gifts, accompanied by a neatly designed Christmas card from the hospital wishing a Merry Christmas and a speedy recovery. The same card is on the breakfast tray of every private patient.

Christmas dinner is as good and homelike as it can be made and everyone who may shares in the seven hundred pounds of turkey that are required for one meal. The extra work is a work of joy shared by all.

To all those who may have the privilege of helping to make this the best Christmas ever enjoyed by the many institutions in America I dedicate this little poem reminiscent of childhood days:



Santa Claus has just visited this group of ward patients at the Decatur and Macon County Hospital, Decatur, Ill.

As I gaze out upon a fleeting landscape gray
 My thoughts hark backward to another Christmas day.
 A bugle bright; the strident rattle of a drum;
 Child voices ring with joy. The old home mem'ries come.
 They span the years that passing time cannot erase;
 The spirit and the joy still firmly hold their place.
 Oh, for a day to blot out intervening years—
 That home again; the joys unmarred by cares and fears.
 But years have flown too fast, though yesterday it seems
 We can't go back. Thank God we still can keep our dreams.

* * * *

As everyone's heart goes out to the children who have to spend Christmas in the hospital it is always interesting to observe the activities in children's wards and in children's hospitals. The many children's hospitals throughout the land present an almost pathetically happy spectacle to the sympathetic observer. Christmas at the New York City Children's Hospital, Randall's Island, where over 1,500 children, or one might say a veritable town of "kiddies," spend Christmas every year is typical of how such institutions all over the country celebrate Christmas.

* * * *

Christmas is a most happy time at the New York City Children's Hospital on Randall's Island. The children begin to look forward to the celebration months before, and talk about it months afterward. Each of the thirty wards has a gaily trimmed Christmas tree; tinsel and glittering snow are set off by many colored lights.

Each child is asked what he or she wishes for Christmas, and, as far as possible, their requests are granted. As many friends of the hospital remember the children at Christmas time, each one is well taken care of.

On Christmas morning Santa Claus goes about each ward, and the children flock about him in droves, looking up at him with an expression akin to reverence. The Christmas dinner consists of chicken, potatoes, vegetables, cranberry sauce, celery, fruit, ice cream and cake. Candy is distributed in large quantities. The blowing of the toy horns and the beating of drums add to the din that fills the whole building.

The nursing school gives an entertainment on the last day before the holidays, and last year a show of magic and sleight of hand was put on between Christmas and New Year's. Live birds,

rabbits and goldfish will appear from the most unusual spots, and we hear the shouts of laughter and cries of amazement which will follow the tricks.

The nurses have a splendid big tree in the nurses' home, and candles burn brightly on each table in their dining room on Christmas morning

* * * *

Perhaps in no other type of hospital is there such gayety and merriment as is found in the mental or state hospitals where the majority of inmates who are able not only make a gala day of Christmas but extend their activities for weeks with various programs, dances and parties. Christmas at the Yankton State Hospital, Yankton, S. D., where over 1,300 patients enter into the activities must be almost a Mardi Gras of gay festivities, according to Dr. G. S. Adams, superintendent, who gives this brief description.

* * * *

A simulated fireplace with the ruddy glow of the open fire is ready to give out its cheer. Santa Claus and his sleigh about to come down the chimney are seen in other places, while in the dining room of the woman's hospital each year, reproduced in miniature, is the manger of Bethlehem, with the wondrous Babe in His rude bed, the mother and Joseph and the shepherds worshiping near, and the lowly cattle kneeling in the background. Everyone becomes imbued with the Christmas spirit, from the superintendent down; the days are crowded fuller and fuller with the "hundreds of things to do before Christmas." Last-minute gifts must be purchased for those who have been forgotten or who have no one to remember them at home, faintly heard are the strains of Christmas carols sung by the practicing choir, the air is laden with the spiciness of mince pies and Christmas puddings, and the ever increasing mail bags make one realize that the day is almost here.

Each year the season seems to mean more to both patients and to these employees who have been here through the year; it is increasingly easier to lay aside the "cares that infest the day," the petty feelings that make life inharmonious, and, with a feeling of camaraderie and of real good will to men, each one seems to strive to make the season for those whose home is here one full of joy and of good cheer.

* * * *

And thus Christmas comes and goes in the hospitals just as it does at home, and through the whole-hearted cooperation of the hospital personnel and the charity of friends it is made there, too, a commemorable day for those confined by physical and mental illness.

EVANSTON HOSPITAL PROVIDES FOR ITS DOMESTIC HELP

By Carl A. Erikson, Schmidt, Garden & Erikson, Architects, Chicago, and Ada Belle McCleery, Superintendent, Evanston Hospital,
Evanston, Ill.

THREE was much discussion before the American Hospital Association adopted the Pledge and Creed beginning "Reverently do I pledge myself to the whole-hearted service of those whose care is intrusted to this hospital," and which closes with "I pray for patience, kindness and understanding in the holy ministry to broken bodies."

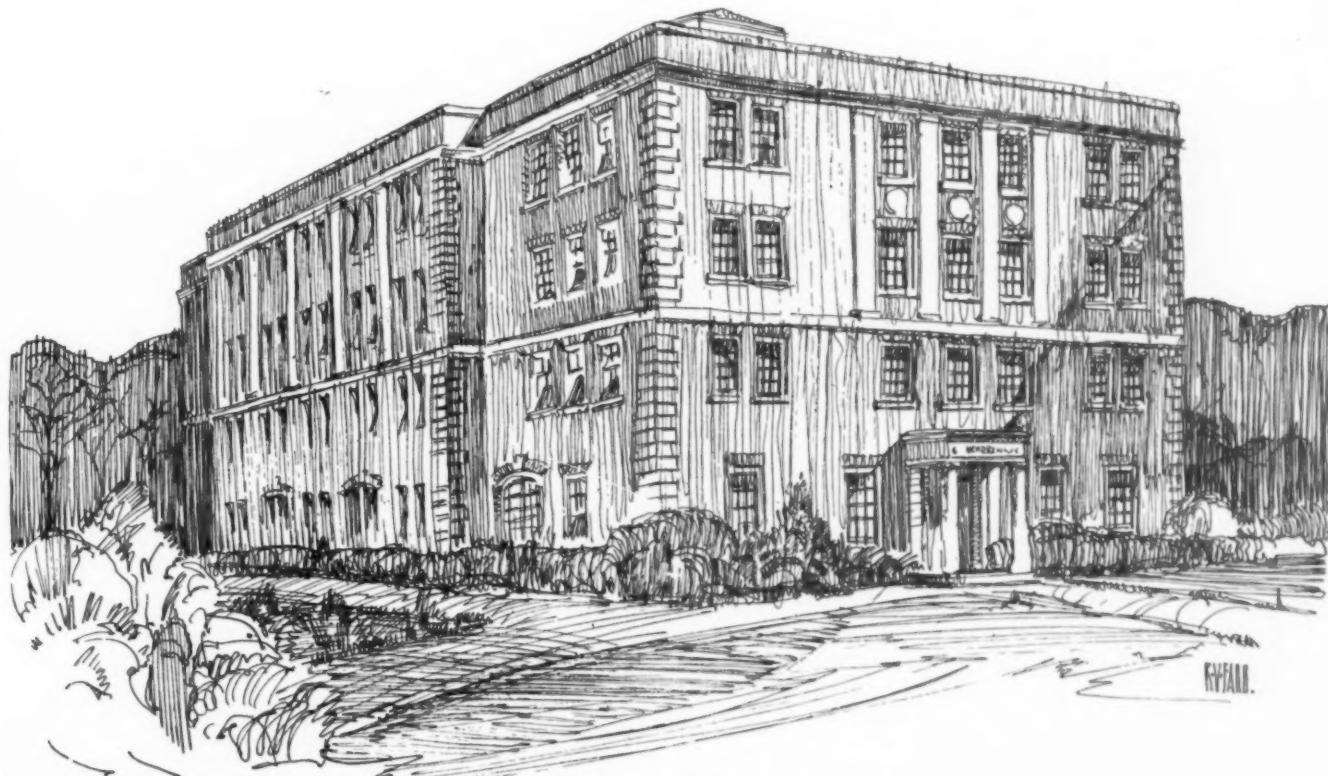
Did those who framed the creed, or those who voted for its adoption, really analyze its meaning? No one person, whatever his qualifications, can carry out the purpose of this pledge alone; no one can carry out its spirit alone; neither can one demand from those who assist in the ministry to the sick that spiritual service which the pledge implies. For the spirit of service must be cultivated and watered, fostered and developed. It will thrive only in good soil. One of the best ingredients for the soil is evidence of consideration for the physical well-being of those who serve.

There is something incongruous in expecting anyone to show a spirit of gentleness if his own physical needs are neglected. The average layman

thinks a hospital consists of rooms and wards, of doctors and of nurses. If, in his own estimation, he is an expert he also has a vision of operating rooms and x-ray equipment. The average hospital worker dwells more upon the technical aspects of the institution. Both groups are inclined to forget that the skill of the doctor, the ministrations of the nurse, and the accuracy of the technician do not provide clean walls, clean floors, clean linen, uniform heat or appetizing food. Yet the workers, who supply these essentials and who are praised in neither song nor story, are usually assigned living quarters in attics and basements. One should not be surprised at the results—lack of interest, dissatisfaction and a high percentage of labor turnover—which constitute the essentials of the labor problem that confronts the majority of hospitals today.

Desirable Quarters Not Available

As Evanston Hospital, Evanston, Ill., is located in the residential section of an attractive suburb, and as it is not possible to secure desirable quarters for domestics in private homes, the question



Hendrey House, Evanston, Ill.

of living outside was solved easily. However, it took great deliberation and careful planning to decide that a building should be erected as a home for hospital workers, a home simple in construction, but giving an opportunity for decent living.

The result of the innumerable conferences was Hendrey House, the building being named in

honor of one who has served the hospital most faithfully for twenty-five years—our chief engineer, William P. Hendrey.

Hendrey House, which is four stories high, stands facing the street, but is set back far enough to allow for a bit of landscaping. Across the street is a public golf green that in all probability will not be disturbed for building purposes for many years as it is a part of the Illinois Waterways property.

The building when completed and furnished will represent an investment of a quarter million dollars. It has two common entrances for both men and women, one from the street, the other from the hospital grounds, but both opening into a public office or lobby.

On both sides of the main entrance are alcoves for reception rooms. On the left is the girls' recreation room and on the right the rooms for stores and for the matron. From the lobby a corridor extends the length of the dining room, leading to the recreation room for the men. At the left of the corridor is the cafeteria dining room. At each end of the building are stairways and elevators leading to the upper floors.

One of the unique features of the building is the plan for the segregation of the sleeping quarters. In each hallway above the first floor is a series of three doorways. On any of these jambs may be hung a fire door. By placing the door at any one of the three entries flexibility will be obtained in the use for either sex of the 120 individual bedrooms. The doors will be locked and the key kept in the superintendent's office.

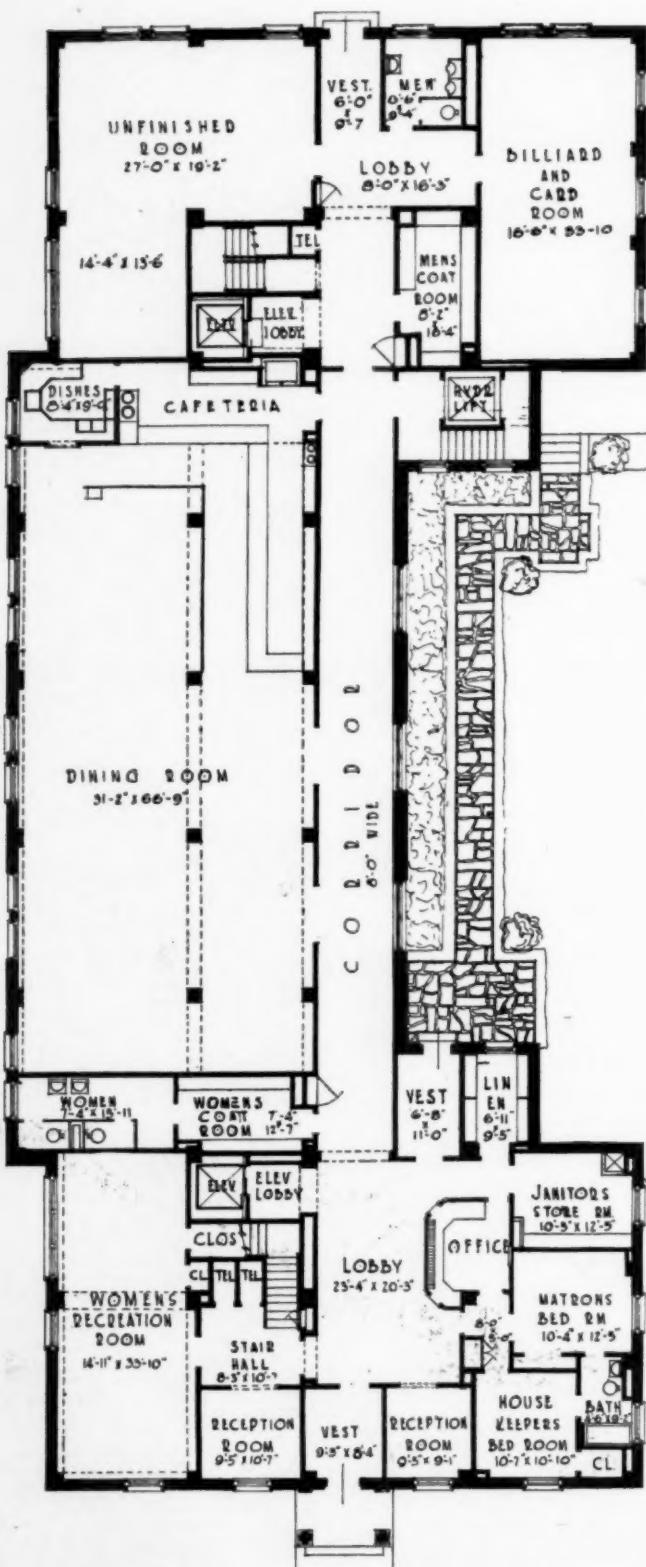
Large Closet for Each Room

Each room has a large clothes closet. There is also room for a 3 foot 6 inch bed, dresser, table and chairs. Both beds and dressers will be of steel. Each room has a window with attractive outlook, none opening on to a court. Each floor will have adequate showers, baths and toilet facilities. One room has been set apart for light laundry work for the women.

The dining room is to have an up-to-date cafeteria, the food being prepared in the main kitchen, carried over and served from electrically heated food carts.

An effort will be made to make the recreation rooms both attractive and usable, as, after all, the end we seek is "whole-hearted service" for "those whose care is intrusted" to our hospital.

In the plans of the first floor the larger rooms explain themselves. Facilities for the reception of the "stranger in our midst" should be noted to the right of the main entrance. Easy supervision of the entrances to the building and to the



Section of first floor, Hendrey House

men's and women's dormitories is obviously essential in a building of this character and determined the location of the office, where are the mail boxes and package receptacles.

Directly back of the office is the only linen room—a commodious one for there are no linen closets on the bedroom floors. Linen will be distributed from this point to the rooms by carts similar to those used in hotels, that is, one with shelves for clean linens, a bag at one end for the soiled linen and at the other end a waste paper bag. Space is also available for miscellaneous items such as soap, toilet paper and other articles that may be needed by the maid. It is expected that this method of linen and supplies distribution will insure better control of both and lessen the labor necessary in caring for them.

The keynote of the interior detail of the building has been the insistence on low maintenance costs and minimum repairs. The floors throughout are of terrazzo, with coved terrazzo base. The door trim is of steel of the flush hospital type. Doors are slab or flush paneled of birch and varnished. Window trim is eliminated and the window stools are of terrazzo. Shower stalls and bath and toilet partitions and the wainscots in bathrooms, toilet rooms and janitors closets are of terrazzo. Such materials are not only easy of maintenance but also vermin-proof, a matter of importance as many hospital executives can testify.

Equipped for Reading Lamp

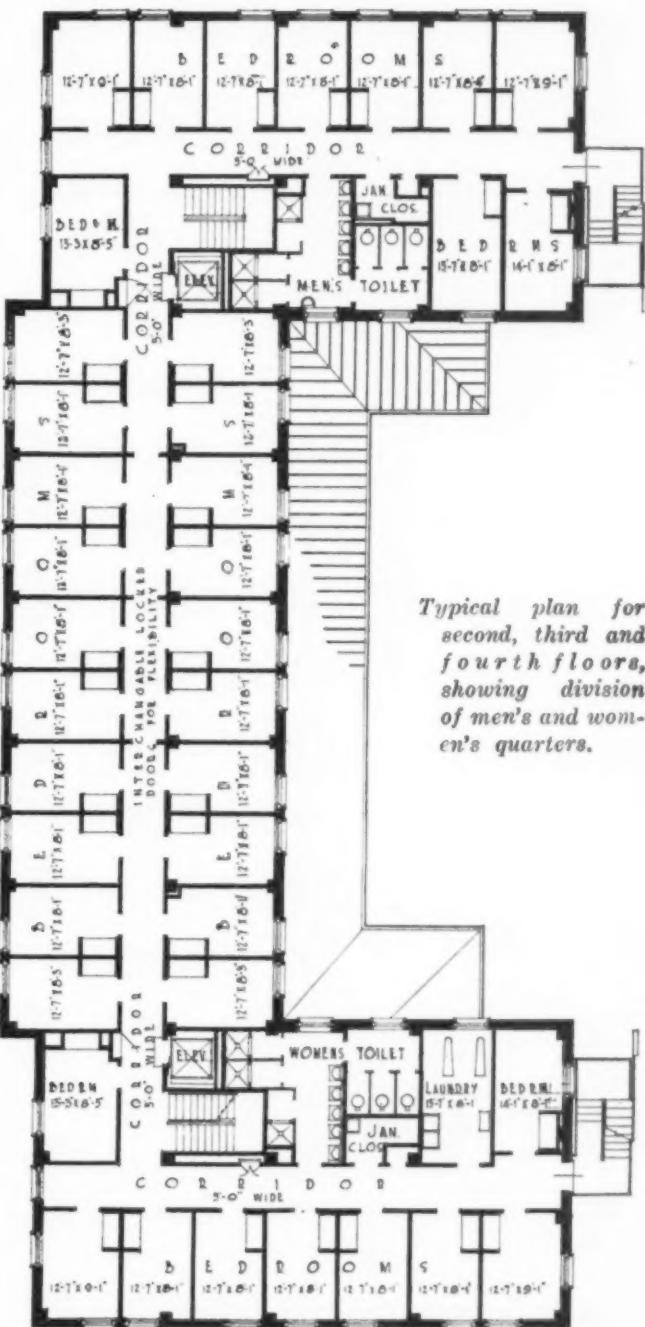
Each room is 8 feet by 12 feet 6 inches. From this must be deducted the wardrobe space which is 2 feet by 4 feet. Each room has a bracket light and an electric convenience outlet for reading lamp.

Outlets for portable electric vacuum cleaners and floor scrubbing machines are installed in the corridor. Public and house phones are to be installed on each floor in addition to those in both the men's and women's recreational centers.

Heating is by hot water from the central power plant, as are all other services of a similar nature. There is no basement in the building. Trunks will be stored in the ample spaces now available in other buildings.

The construction is, of course, fireproof, reinforced concrete skeleton and floor slabs. The exterior curtain walls are of face brick "backed up" with hollow clay tile. The building is designed so that it can carry an additional story, increasing the capacity to 165 rooms.

The exterior is of a reddish brick, quite variegated in color, of a sand finish and laid in white mortar, the joints flush with brick. The buff artificial stone is rather sparingly used as trim, to



Typical plan for second, third and fourth floors, showing division of men's and women's quarters.

"high light" the building, as it were. The effect is reminiscent of the Georgian buildings of the Adams Brothers and closely akin to the design of the main building of the hospital, completed in 1921.

Will Attract Better Help

It is expected that this building will go far towards solving the problem of domestic help. It is clearly recognized that no amount of creature comforts will offset the pittance so often paid the hospital domestic personnel, but it is reasonable to expect that a home such as Hendry House will attract the best grade of help and keep them in the service longer, avoiding the expensive and disruptive labor turnover.

WHAT IS PHYSICAL THERAPY?*

By Norman E. Titus, M.D.,
New York.

ALTHOUGH I do not desire to make this paper resemble a few pages of a textbook, the title is such that I think the first thing to bring to your attention in answer to the question "What is physical therapy?" is a definition. If you can keep the definition in mind, I feel that you will understand the whys and wherefores of physical measures to a greater extent. Such a definition would be: Physical therapy (generally known as physiotherapy) is the use of physical measures in the treatment of pathology in an attempt to convert an inadequate reaction into one that is adequate to overcome physiologically the condition at hand. This explains what we try to do when we administer the different modalities that are included under the heading of physical therapy.

There is another way of considering physical therapy. This is a definition of my own which deals in percentages. I always feel that of the entire subject, 95 per cent is ordinary medical common sense. This part is in the equipment of every medical graduate. Of the remaining 5 per cent, 3 per cent is an understanding of what physical therapy can do and the other two per cent is the technical knowledge that we who administer the treatments must have in order to accomplish the results we desire. This technical knowledge has to do with the running of the machines and the actual application of the modalities.

Physical therapy is probably the oldest kind of therapy in the history of the world. From time immemorial sunlight, exercise, water, and even steam and hot air, have been used by the peoples of the earth in an attempt to treat certain diseases. Only recently I heard a man say that in exploring in the interior of Brazil he found a tribe of people who were ignorant of all details of modern medicine, but they had realized for centuries

that in the treatment of skin conditions nothing could equal sunlight. This explorer told me that in talking with the medicine man of this tribe he learned that even though the whole hospital hut was infested with flies, the people with skin ulcers who were being treated in the sunlight did not have anything but good results if they had plenty of sun.

The great physician, Sir William Osler, said before he died that three forms of therapy were just being started, the results of which would bring about great advances in medicine. He said that the first two, of equal importance, were endocrinology and psychiatry, but that the greatest field where the most work could be done with the greatest ultimate benefit, and which he considered one of the important things in the future of medicine, was physical therapy. Medicine goes through different phases of en-

thusiasm and as you all realize more attention has lately been paid to diagnosis and the laboratory side of diagnosis than ever before. Attention now is turning toward therapy and it is because of this trend that physical therapy will, I am sure, be more fully investigated and placed on more scientific foundations than has hitherto been the case.

The general public today is not satisfied with just receiving prescriptions or a bottle of unknown medicine and then sitting around to await results. The medical profession as a whole, as stated by Dean Walter H. MacCracken of the Detroit School of Medicine and Surgery, Detroit, is largely responsible for this situation. Massage always has had a distinct place in general therapeutics but doctors in the past, desiring to be more scientific in their appearance and procedures, have neglected such a simple means of treatment as massage, and hence the different cults have sprung up and taken what rightfully belongs to medicine by basing their treatments on massage and varia-

*Read at the twenty-eighth annual conference of the American Hospital Association, Atlantic City, N. J., October, 1926. Released and publication authorized by the association.

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tions of it. Had the medical profession retained the right given it to direct and administer all forms of treatment, Dr. MacCracken says, the cults would not be making the progress they are today because the patient wants something done and massage at least does something at the time even though it is not the correct therapeutic procedure that should be instituted.

Physiotherapy Defined

Referring to the definition quoted above, you will see that I said physical therapy is used in an attempt to convert an inadequate reaction into an adequate one. It is important to observe the word "attempt" because the procedures known as physical therapy never can be classified as curative, with two exceptions. The first of these is the surgical use of high frequency electricity where tissues are destroyed and removed the same as with any regular surgical procedure. The second exception is the use of ultraviolet light in special diseases, such as rickets.

Another limitation of physical therapy is that, inasmuch as it is largely symptomatic treatment, it is never a method that can stand alone. It is never independent of recognized medical and surgical procedures. Men who are fanatics in this line are all too prone to try to cure things with physical therapy alone. Too many of the pioneers in this work who were insufficiently grounded in diagnosis, have done harm to physical therapy in their over-enthusiasm, and the methods they have pursued in trying to force these methods of treatment down the throats of the general medical profession. Consequently, before describing these procedures, let me impress upon you that physical therapy is used in an attempt to help the condition when such procedures are indicated; it is never a cure and should never be used to the exclusion of other recognized and sane medicine and surgery.

Now let us look into what physical therapy can do. With the modalities available we are able to produce thermal, chemical and mechanical reactions in the living body, all governed by the laws of physics and physiology. When the doctors on different staffs of hospitals understand how really simple and unmysterious the 98 per cent of physical therapy is, they can quickly grasp the subject. Ninety-five per cent of them already have and can rationally prescribe most of the modalities for their patients.

I am sure most members of hospital staffs have no exact idea of how mixtures are made up that are listed in hospital formularies. They know what the contents of these mixtures are, and they know the effects that the components will produce.

Therefore when a doctor orders "Respiratory No. 4," for instance, he knows exactly what effect he wants and why he wants that effect, but he has no idea of the purely technical knowledge of compounding this mixture. In like manner when a member of the staff orders diathermy for a patient, it is easy for him to understand what the effect produced will be, but it is not necessary for him to know how the machine works or exactly how the application is made. Physical therapy is never mysterious and one can easily find out how every modality works. We who are teaching this subject try to take away all the mystery that has surrounded it for so many years. I would not try to compare it too closely with *materia medica*, but there are many drugs whose origin and action are not exactly known by the clinician, whereas it can be explained exactly how physical modalities are made and how they work. It is almost sufficient for a prescribing physician to note on a patient's chart that he desires thermal and mechanical effects to be induced, leaving the director of the department to his own devices as to how to induce the effects.

Prescription by Staff Members

However, it has been our experience that doctors who could prescribe in such a simple way, being modernly trained men, are not satisfied to evade the issue and generally desire a more intimate knowledge of physical therapy. In hospital work it has been found a good procedure from the viewpoint of the department of physical therapy either to request or require the members of the hospital staff to make their own prescriptions, as this stimulates their interest. All prescriptions, however, should be reviewed and approved by the medical director of the department so that the results accomplished shall be what are desired. A poor prescription cannot be expected to accomplish good results and when good results are not attained the first man to complain about them is generally the one who ordered the treatment by a poor prescription.

I will not go into the matter of records and prescriptions for a department of physical therapy because it was indirectly through your organization that a complete description of the Beekman Street Hospital System of Physiotherapy Records was published in **THE MODERN HOSPITAL** in May, 1925. That system was started in 1924 and is still in use at Beekman Street Hospital, New York. It has been found successful and has been adopted either exactly or with slight modifications by many hospitals.

I shall now bring to your attention the modalities we use to induce the thermal, chemical and

mechanical reactions that I referred to before. We have really three ways of inducing changes in temperature without and within the human body. You will notice that I make a distinction between the location of these thermal effects. The effects of the old fashioned "bakers," either of steam or hot air, and warm water, from a purely thermal viewpoint are always brought about on the surface of the body. Even mustard plasters, flax seed poultices and actual cautery never induce any change in temperature beneath the true skin. Their effects are more from the reflex counter-irritation they induce. By means of light and electrical currents, however, we are able actually to raise the internal temperature of any part of the body to any degree we desire. Radiant energy from any glowing or incandescent source follows the laws of light and, as was proved years ago, is capable of penetrating to a depth of one and one-half inches beneath the skin surface.

"No Such Thing as Light"

Perhaps you will be surprised at the statement that there is no such thing as light, as such. What I mean is that light is energy in motion following certain laws and wave lengths, but it has no effect, nor can it be perceived by the eye or any other method, unless it is stopped in its motion. The old law of physics concerning the conservation of energy makes it a fact that energy in motion, when stopped, becomes heat. Consequently, when we project this energy from a radiant source upon the skin of a patient, as far as any vibrations will penetrate before they are stopped, just so far beneath the surface shall we be able to create heat. I shall not go into extensive physiological explanations regarding this fact because it is easily appreciated when it is realized that we are dealing with the vibrations of the ether, which when stopped produce the effect we perceive as light, and physically, at the same time, produce heat. The differences in wave lengths of light only alter the depth of their penetration. We know that there are wave lengths that cannot be perceived by the human eye, the longest ones being called the infra-red rays and the shortest ones being called ultraviolet rays. You would be surprised to know how many otherwise well qualified clinicians believe in the deep penetration of ultraviolet rays. This is a myth, because ultraviolet rays are so short they do not penetrate more than one-tenth of an inch beneath the skin surface. There is some dispute going on regarding the penetration of infra-red rays, but the consensus of opinion and the opinion of a few of the physicists who know anything of the clinical side of this work, is that infra-red rays are all

entirely stopped on the surface of the human skin.

While speaking about these two kinds of light it is worth mentioning that neither of them will pass through glass and consequently ordinary window glass is as opaque to the therapeutic rays of sunlight as a piece of wood. One example of this is the fact that people do not get sunburned when sitting in modern solariums such as exist today, even though they sit in the direct rays of the sun. An interesting historical fact is that glass was not discovered until about 1700 and after its introduction the well known disease rickets was first discovered, and hand in hand with the growing increase in the use of window glass the prevalence of rickets has also increased. The only kind of glass-like substance that passes all ultraviolet rays is fused quartz, but as yet the price of this is so prohibitive that it cannot be used commercially. Scientists all over the world are realizing that quartz, which could be used in windows, or some composition of quartz, is worthy of great investigation because of its being almost a necessity, especially in buildings where sick people are being treated.

In treatment with radiant light such as is generated by incandescent bulbs, it is necessary to issue a word of warning regarding the actual technique of application. Not long ago I was asked to investigate a situation in a hospital where patients, being treated with electric light applicators, were burned by the light. I found that in making these applications the operators, who were all students in a commercially promoted so-called "physiotherapy school," were accustomed to placing the part to be radiated under an applicator and then covering the whole with a blanket. In this way the patients were receiving a double dose of heat. The blanket was keeping in all hot air and non-radiant heat generated by the apparatus and reflectors, and the light energy was also generating heat in and about the part being treated. Consequently the patients received some slight burns.

Perspiration Stops Light

Perspiration is an effective substance to stop light and heat rays and if we desire the effects of our light to be deep within the tissues, it is necessary that we allow all perspiration to evaporate as it is formed. Therefore the word of warning I wish to mention is this: whenever radiant light is used in treatment it is of the utmost importance that the parts be exposed to a free circulation of air. In cases of open wounds and extensive burns of the body, in order to keep flies and other insects away it has been found practical to cover the applicator and the patient with mos-

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quito netting. One should also always realize that radiant heat does not have to be felt as great heat by the patient. Some of the lights that are used are never placed nearer the patients than six feet, and on the skin the patients feel only a very moderate warmth. Inasmuch as light is traveling in straight lines to the tissue, we are sure that it is penetrating within a tissue and producing the effects we desire therein.

The third method of creating heat within the tissue at any depth or location we desire is the use of high frequency electricity. This procedure is generally known as diathermy. This subject could well be treated in a single paper but I shall endeavor to give you some enlightenment of its mode of action and a brief description, because to appreciate its great efficiency it is necessary to realize to some extent the way it works.

In current medical literature we read more and more of the use of diathermy. The writers too frequently attempt to attribute all beneficial effects to diathermy alone. It is true that some conditions are greatly benefited by the use of diathermy without any other measures. This is merely because in these few conditions the production of heat within the tissues causing a physiological hyperemia, allows the body to convert the previously inadequate reaction into one that is adequate, so that healing and restitution of function can be accomplished by the body. In such cases it is better to admit that diathermy did not "cure" the condition but that it brought about such a reaction that nature itself effected the cure. Diathermy by its irritating effects in causing deep hyperemia was merely the means of throwing the balance over to the side where the normal physiological processes of the body could bring about a cure of the condition.

Chemical Effect of Physical Therapy

The second effect that can be brought about by physical therapy, is the chemical effect. Here again I could spend the entire time allotted to me bringing up the scientific and clinical observations that go to bear out the fact that ultraviolet rays have a great chemical effect on the metabolism of the body. Medical literature these days is full of this, especially in the treatment of rickets, and if there is one thing in which ultraviolet rays are specific, it is in the treatment of rickets. There are many theories regarding the way in which these chemical reactions are brought about, but this is not the place to bring out theories for discussion.

In a recent number of the *New York Journal and Medical Record* the well known investigator Sajou brings out a theory of the action of light of

all kinds that contradicts some of the almost accepted theories of the action of ultraviolet rays. Suffice it to say regarding ultraviolet that we have an interesting modality the effects of which are not entirely known today, but with each investigation we find more and more what a powerful kind of energy we have that can be used to great benefit in the treatment of many metabolic disturbances. There is also a side of ultraviolet that is not strictly chemical and that is shown in the way it is used for superficial infections because it has a powerful germicidal effect. It is the ultraviolet of sunlight that does the sterilizing on the surface of the earth.

Faradic and Sinusoidal Current

Chemical effects can be produced electrically by the ordinary galvanic or battery current. These depend upon the old ice pail experiment of Faraday which proved that like bodies repel and unlike attract. Consequently when we use the acid forming pole of the galvanic current we can attract bases to it and repel chemicals of acid electrical reaction. Conversely we can use the other pole to disseminate bases and attract acid radicals. I shall not go into the intricacies of galvanism and other variations of this current such as faradic and sinusoidal, but they have their different uses in the field of physical therapy in producing effects.

The last reaction of the three I mentioned above was mechanical. The original well known mechanical effects produced by massage and exercise of different varieties may be considered first under this classification. The use of massage and exercise is being extended a great deal in these modern times. I can mention the fact that at Beekman Street Hospital all fracture cases have this form of treatment initiated practically within the first twenty-four hours after admission to the hospital. It is with these procedures that parts adjacent to the fracture are kept in condition and nothing is ever done to the site of fracture by the department of physical therapy. That portion is handled entirely by the surgical department but it is the function of our department to keep the patient in condition and to prevent the other joints from becoming fixed so that when the fracture is healed the period of recovery is greatly shortened and he is the sooner prepared for return to his occupation.

Besides massage and exercise we have two potent electrical methods of producing mechanical effects. Of course there are electrical machines producing exercise but they utilize electricity merely as a means of saving the energy of an operator, who by treating the patient personally

would produce better results than these electrical machines are able to. The electrical modalities we use are the sinusoidal current, which is a variation of the galvanic and is used mainly for exercising muscles, and the grandfather of all electricity—static electricity. Most people believe that galvanic electricity was the original current but history shows that a static electricity was known and used therapeutically for 150 years before galvanism was discovered.

In order to understand the fundamental peculiarities of static electricity, let me compare electricity to water in a system of pipes. If we have a stream of large volume but low pressure, that is comparable to an electric current of high amperage but low voltage. If we reduce the volume and increase the pressure, it is the same as reducing the amperage and increasing the voltage. According to this comparison, static electricity is a small stream of water under very high pressure and the modern static machines are capable of producing extremely high voltage but little volume or amperage. Consequently the effects of the static current are almost entirely mechanical due to its being a moving force under great pressure. With the static current we can force out by the pressure alone, infiltration and congestion and we use this current as a decongestor whenever it is required. Static electricity can induce the mildest or the most powerful mechanical effects and much less or greater than can be produced by massage. There are many cases where the best results with physical therapy could not be achieved without the use of static electricity.

Water One of the Oldest Agents

One of the oldest mechanical agents that is generally used for many conditions is water. Hydrotherapy also combines the use of some heat but most of the effects are produced by mechanical friction of the water as is shown in the most extensive modern use of this modality, the whirlpool bath. The whirlpool bath, besides conducting heat to the part, functions mainly as a mild massage which is particularly sedative and has been found beneficial where it is desired to alleviate pain in an extremity or cause a slight stimulation of regeneration as in chronic ulcers. Another form of hydrotherapy that is not mechanical but is of great use, is the treatment of stumps after amputation with contrast baths of very hot and very cold water. This action toughens the skin and helps the patient to use his false arm or leg in a shorter period.

In conclusion let me state that physical therapy is an added tool in the equipment of a modern hospital. It has a distinct place in almost every kind

of therapeutic team work and can be counted upon at all times to reduce the period of hospitalization and convalescence of most patients. It never was a competitor of recognized medicine and surgery and as soon as this fact is appreciated by the over-enthusiasts, the sooner shall we have recognition of physical therapy in the world of modern medicine.

PROVIDING CLINICS FOR MIDDLE-CLASS PATIENTS

The question of maintaining evening dispensaries for the benefit of the sick poor, who, on account of their work, are unable to apply for treatment to dispensaries open only in the day time, is worthy of consideration in all communities. This more especially is true in view of the great field thrown open by the advocacy of periodic health examinations.

The Health Service Clinic of the Postgraduate Medical School and Hospital, New York, inaugurated in January, 1925, an evening clinic for health examinations and guidance. Since its beginning nearly one thousand persons have applied for its services. The field this clinic serves is made up largely of persons in moderate circumstances, such as workers, clerks, school teachers and stenographers.

The clinic is not of the charity type. A fee of \$5 is charged, which is waived in needy cases. The fee, however, does not defray the expenses of the work, therefore an effort is made to restrict the service to those unable to pay the fee which would be necessary elsewhere for such examinations. The individual is referred to his own regular physician for any treatment needed.

The altruistic work could be adopted in many communities to the distinct advantage of both the individual, who is the main consideration, and the practitioner.—*The Atlantic Medical Journal.*

THE HOSPITAL IN POETRY

For those who have known and have been associated with hospitals the 1927 "Hospital in Poetry" calendar, published by the National League of Nursing Education, will hold a peculiar interest. The humor, pathos and drama of the incidents and the events that make up hospital life are all expressed in the poems by Stevenson, Guiterman and others, and the fourteen vignettes by Bennet-Runyon, with a frontispiece in color by Anna Milo Upjohn, add artistry and charm. The price is one dollar per single copy and seventy-five cents per copy on orders of fifty or over, delivered in one shipment. Orders may be sent to the National League of Nursing Education, 370 Seventh avenue, New York.

1750-1926

Of interest to hospital people who visited the Sesquicentennial Exposition at Philadelphia, is a reproduction of the first official hospital for general use, established in 1750. The little place has just one room. It is equipped with quaint wooden cupboards and one double wooden bed, the springs of which are made by evenly criss-crossing rope in squares from wooden pegs driven in the side boards. The later development of this tiny place is the Pennsylvania Hospital of Philadelphia, an institution that now has 310 beds.



Fig. 1. Play room at the Sarah Morris Hospital for Children, Chicago.

SPECIAL hospitals for children are of rather recent origin. The first hospital of this type in Europe, the Great Ormond Street Hospital for Sick Children, was established in London in 1852. The first children's hospital in the United States, the Children's Hospital of Philadelphia, was built in 1855. Now, however, most larger cities in this country have special hospitals for children. Both the physicians and the laity have learned that certain diseases of childhood can be treated better in a hospital than at home. This is especially true in regard to surgical diseases, some of the acute infectious diseases, such as pneumonia and typhoid fever, and some feeding disturbances.

A children's hospital should be located in a quiet neighborhood. It seems like the irony of fate to see a hospital for children in a congested district, a few feet away from a market place or from a railroad yard, and the only indication of the necessary quiet is the sign "Zone of Quiet." The ideal location for a hospital for children is an uncongested part of the town, close to a park, surrounded by trees and grass, yet not too distant from the center part of the city to make transportation for poor people difficult.

A special building for treatment of children, no matter how small, is preferable to a ward of a large hospital, no matter how large the ward may be. The children in a ward of a large hospital will learn about diseases of adults, will hear the screams of women in labor and the groans of people who have met with accidents. During con-

valescence they cannot but come in contact with older patients whose outlook on life is either pessimistic or cynical.

If possible, a children's hospital should consist of more than one building; a separate structure for medical diseases, another for surgical cases and still another for infectious cases. This, however, is not always possible. Under no circumstances, however, should contagious cases be placed in the same building with other cases.

If the children must be treated in a ward of a general hospital, the ward should be on a separate floor, or at least on the floor where only medical cases are treated. No children's ward should be on the same floor with obstetrical or surgical cases, as children are prone to get infections, and in turn may transmit infections to the obstetrical or surgical cases.

Not only children's wards, but even special hospitals for children are often connected with general hospitals, such as the children's pavilion of Mount Sinai Hospital, New York, and the Sarah Morris Hospital for Children of the Michael Reese Hospital, Chicago. The question often arises as to whether the children's hospital should have its own kitchen and laboratory or should utilize the equipment of the general hospital. Experience has taught us that it is to the advantage of the patients to have the children's hospital possess complete autonomy; especially should it have its own milk kitchen and laboratory. Some European hospitals for children even have their own x-ray laboratory, as, for instance, the University Children's Hospital, Vienna. This, however, is not always possible. In addition to one or more attending pediatricians, the staff of

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FEATURES THAT DISTINGUISH A CHILDREN'S HOSPITAL

By Abraham Levinson, M.D.*

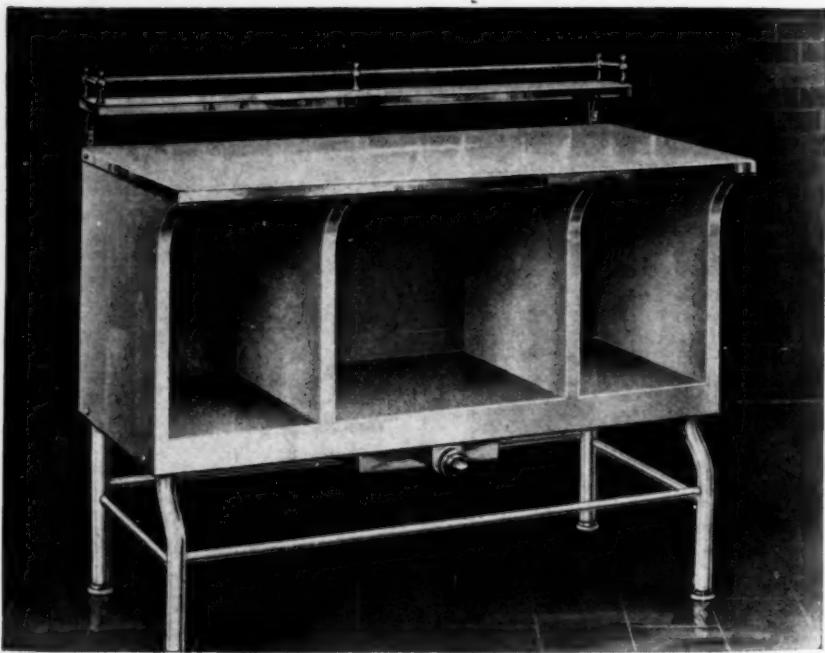


Fig. 2. An electrically heated dressing table.

the hospital should include specialists in general surgery, orthopedic surgery, neurology, eye, nose, ear, and throat.

A hospital for children should have observation rooms, where every newly admitted patient should be kept for two days to make certain that he does not suffer from a communicable disease. During these days, nasal and throat cultures and vaginal smears should be taken daily, the skin should be examined for rashes and the mucous membrane for enanthemata, especially for Koplik's spots.

Isolation rooms are also essential for patients who develop a suspicious rash, a suspicious cough or a sore throat. The patient should be kept in the isolation room until he recovers or at least until a positive diagnosis is made and then sent to a hospital for contagious diseases.

A feeders' room should be provided for infants who have come to the hospital for correction of feeding. In a well regulated hospital the feeding patients who have no diarrhea should be kept separated from infants suffering from diarrhea.

In addition to a ward for feeders, the hospital should have a room for normal babies. Strictly speaking, normal babies do not belong in a hospital. Unfortunately, each hospital for children harbors at least one normal infant. These come to the hospital because their mothers are sick and there is no one at home to take care of the infants, or because they are to be examined for adoption, as is often the case with illegitimate children. These infants should be kept apart from all other patients, otherwise they will contract some infection and the results may be disastrous.

It is advisable to have a special room or even

more than one room for premature infants. In such a room, the temperature can be kept even, the ventilation good and the highest degree of aseptic technique observed. Of course, when no special department for premature babies can be installed, an incubator should be placed in a ward.

There should be a quiet room to be used for critically ill patients and for children requiring an extraordinary amount of rest, such as those suffering from tetanus, meningitis, or chorea.

The general ward is used for miscellaneous cases, such as diseases of the kidney and heart and other medical and surgical conditions. During the winter, a special pneumonia ward is often a necessity.

There should be a dressing room on every floor or at least, one for every two floors, where patients can be taken for spinal puncture, sinus puncture, thoracentesis, and minor surgical dressings. It is inconvenient and also psychologically wrong from the standpoint of the other patients to perform any special procedures in the general ward.

It is essential to have a play room for convalescent cases. The play room may also be used for instructions. (Fig. 1.)

An elaborate milk kitchen with many utensils, where the feedings for infants are prepared, is no longer considered necessary. A simple room will do.

In line with the idea of autonomy, the hospital for children should have its own operating room or rather two operating rooms, one for major surgery, and one for nose and throat. If the operating room of the general hospital must be used, the two hospitals should be connected by a tunnel so as not to chill the patients on their return from the operating room.

Heliotherapy is so important in the treatment of diseases of children that it behooves every hospital treating children to have a special solarium where the children can be sent for sun baths. Space on the roof may sometimes be utilized for heliotherapy. It should, however, be protected by canvas in case of rain or burning sun.

Every hospital should have a special laboratory where clinical tests and if possible also research can be carried on. In children's hospitals connected with large hospitals, the more complicated tests, such as Wassermann and Lange or blood

chemistry, will necessarily have to be carried out in the main laboratory. Simple procedures, however, should preferably be performed in the laboratory connected with the children's hospital.

A pavilion for contagious cases is a valuable addition to a children's hospital. Not every hospital for children, however, can afford such a pavilion.

If possible every hospital should be intimately connected with a convalescent home where it can send convalescing patients. A convalescent home will hasten the patient's recovery and will save the hospital many a bed.

In addition to the medical and surgical departments proper, the hospital should have two auxiliary departments or organizations, namely, social service and dispensary or out-patient department.

The equipment of a hospital for children must necessarily depend on the number of wards and the number of patients in it. A certain amount of equipment, however, is necessary for every hospital, whatever its size.

The rule should be to have as little furniture in the hospital as possible. The most necessary pieces are: Beds, bassinettes, bedside stands, sinks, desks and chairs.

The hospital should have in addition to the furniture in the hospital, the following armamentarium: Showers and bathtubs, scales, screens, stands for gowns, electric food carts, food trays, quartz lamps, incubators, breast pump.

Instruments necessary in carrying on the work of the hospital are: Thermometers; needles for venipuncture, spinal puncture, sinus puncture, thoracentesis, intradermal tests; syringes; catheters; lavage and gavage outfits; transfusion apparatus; Pirquet bore and tuberculin; intubation and tracheotomy outfits.

The following utensils are also desirable: heart binders with pockets; empyema binders with pockets in back; eczema cuff and masks.

The old-fashioned narrow bed with low sides is very unsatisfactory, especially for children be-

tween two and five years, as there is danger that the child may fall out. A stationary bed has the disadvantage that it is hard to move it to the porch. Beds with adjustable casters and high sides are preferable.

No back rest is necessary for most beds. There should, however, be a few special beds in the wards equipped with back rests to be used for cardiacs. When no special beds are available, a back rest may be improvised.

The very small bassinettes used in some hospital nurseries are unsatisfactory. Wide bassinettes with high sides are better. The bassinettes should have casters so that they can be moved around with ease.

Each bed should be provided with a bedside



Fig. 4. Bedside stand that is needed for each bed.

stand. Each stand should have sufficient space for a comb, brush, toothbrush, towel, wash cloth, and mouth wash solution or tooth paste. (Fig. 4.)

Sinks with arms or foot pedals are better than those operated by hand. Green soap in cans or patient containers is more economical than soap cakes.

The nurse needs a desk and chair for the preparation of her records. If possible, the desk and chair should be placed in an anteroom. If not, they should be placed in the ward proper. It is inadvisable to have only one desk and chair for the whole hospital or even for a whole floor, as it encourages nurses to trust their records to memory. The method of charting depends necessarily on the ideas of the attending staff and head nurse. A graphic weight and temperature curve is a convenient way of keeping children's records, as years of experience indicate.

Showers are preferable to bathtubs as they do away with the chance of transmitting infection

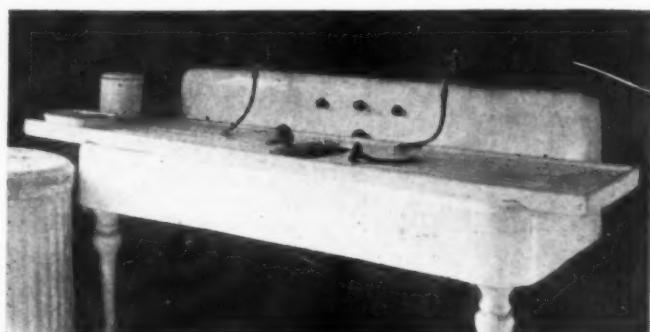


Fig. 3. Sink, table and spray for bathing infants.

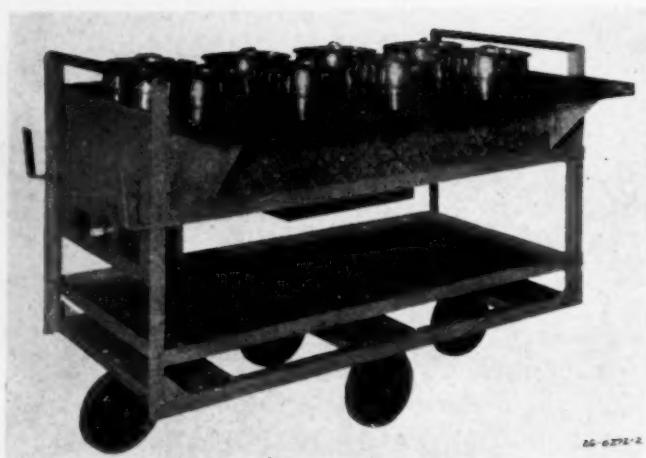


Fig. 5. An electric food cart for keeping food warm.

from one child to another. If bathtubs are installed, they should be cleaned each time they are used.

Separate infants' and children's scales are necessary. The children's scale should have a rod attachment for measuring height. Gram and kilogram weights are preferable to pounds and ounces.

Sheet metal screens are satisfactory, as they can be washed. They are however, expensive. A screen frame with linen sheeting attached to it will suffice.

Stands for gowns and stands for basins should be kept in the isolation room. The basins should be filled with 1:5000 solution of bichlorid of mercury, $\frac{1}{2}$ per cent of phenol, or any other anti-septic solutions. Towels and soap should naturally also be supplied.

Electric foods carts to keep the food warm while it is being served are an important addition to a hospital. (Fig. 5.)

For very sick children flat food trays should be used. For convalescent children, trays with legs should be used. Aluminum or other metal trays with round corners are preferable to wooden trays with flat corners, as crumbs get into the wooden trays.

Quartz lamps are desirable for treatment of premature infants, rickets, and various forms of tuberculosis.

Incubators are necessary for premature infants. An incubator can be made at home as follows:

An ordinary clothes basket is padded both inside and out with several layers of newspaper. These are covered with sheets that are kept in place with safety pins. A sheet is also used to cover the top of the basket, with an open slit in the middle to allow for ventilation.

An electrically heated examining table, as devised by Dr. Joseph B. De Lee, Chicago, is very important in wards for premature infants and

in the care of very young normal infants. (Fig. 2.)

Abt's electric breast pump is a valuable addition to a hospital where wet nurses are employed. It may also be used by mothers whose milk supply is scant. Recently Dr. Abt described a water run pump which is much less expensive than the electric pump although it is less efficient. The old-fashioned glass breast pump usually irritates the breasts considerably and the amount of milk obtained often does not justify the effort.

Whenever an electric or water run breast pump is unobtainable manual expression is preferable to a glass breast pump.

Individual thermometers should be used, and each thermometer should be kept at the bedside stand in bichlorid in a wide-mouthed specimen bottle.

There are divergent opinions as to whether all thermometry in children should be rectal, axillary, or oral. Most pediatricians nowadays prefer rectal thermometry as it gives the most accurate results. Separate rectal and mouth thermometers are on the market.

Good Supply of Needles Necessary

A good supply of needles is of the utmost importance for a children's hospital. The selection of the proper needles for various pediatric procedures is an art and this selection should be made by the superintendent with the full cooperation of the medical staff. It is not in the province of this article to give a systematic treatise on needles and only a general outline of the special needles will be given here.

Venipuncture needles are to be used for older children. The needles should be 1 to $1\frac{1}{2}$ inches in length and 22 gauge.

In older children the ordinary spinal puncture needles used for adults may be employed, namely 2 to $2\frac{1}{2}$ inches long and 20 to 22 gauge. In infants, however, it is best to use a shorter needle although the gauge may be the same as in the ordinary needle; namely 20 to 22.

A needle, which consists of a 20 gauge Luer, a stylet, and a stopcock, one end of which can be attached to a spinal manometer is quite convenient for taking pressure readings.

Sinus needles should be $\frac{3}{16}$ to $\frac{1}{4}$ of an inch in length, and may be purchased or improvised by filing down a spinal or venipuncture needle to the desired length, making the bevel short.

Thoracentesis needles should be about $1\frac{1}{2}$ inches in length and 20 to 22 gauge.

Intradermal needles for skin tests should be of 26 gauge. These should have very short points to prevent the fluid to be injected from escaping.

Several syringes of different sizes should be on

hand. The most important sizes being 1 cc., 10 cc., 20 cc. and a special 1 cc. syringe, graduated to one-hundredth of a cubic centimeter to be used for intradermal skin tests.

The hospital should be equipped with rubber catheters of various sizes: (a) A wide rectal tube; (b) catheters varying between No. 10 to 16 French, to be used for lavage or gavage and a No. 10 French soft rubber catheter, to be used for urethral catheterization. A special duodenal catheter has also been described; (c) a modified steel eustachian catheter may be used as a urethral catheter for female infants.

The lavage outfit consists of: a soft rubber catheter 12 to 16 French, glass tubing as a window, and a funnel. A pitcher containing the solution to be used in washing the stomach, and a basin in which to receive the washings should be on hand.

The gavage outfit required is essentially that used for lavage. However, a large syringe and catheter, or a syringe barrel and catheter may also be used. (Fig. 6.)

Transfusion of fluids is so frequently given in pediatrics that an apparatus should always be on hand for this purpose. One and the same apparatus may be used for introduction of normal salt, of glucose and of blood. The apparatus found most useful consists of a graduated open cylinder, a rubber tube, a clamp, and a barrel of a tuberculin syringe. (Fig. 6.)

With regard to the Pirquet bore and tuberculin, an aluminum bore with a long handle is preferable to a short steel bore. A supply of tuberculin, preferably O. T., should always be kept on hand. Tuberculin in one c.c. bottles is more economical than that which is put up in individual tube points.

Two Intubation Outfits

There are two popular intubation outfits on the market: the O'Dwyer instrument, which consists of hard rubber tubes lined with metal sheeting, a separate obturator for each tube, and a separate introducer and extractor. The second type of intubation outfit is the Ferrouard instrument which consists of metal tubes with one handle to be used both for intubation and extubation.

The best tracheotomy tube is one made of silver or aluminum, not of lead. In an emergency, a tracheotomy tube may be improvised by cutting off a piece of a large rubber catheter.

Even when no contagious cases are admitted, the hospital should be provided with an intubation and tracheotomy outfit.

The ice bag often used in treatment of cardiac disease, does not always stay over the heart re-

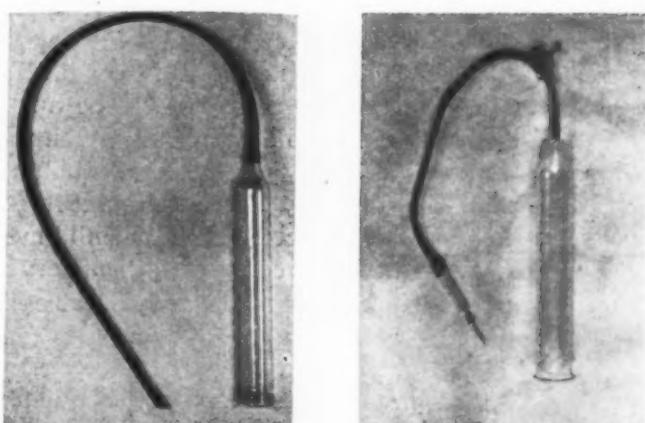


Fig. 6. Left, gavage outfit; right, apparatus for blood transfusion.

gion even though it may be pinned to the gown. A binder with a pocket to hold the ice bag firmly over the heart is therefore quite advantageous.

A binder with a pocket in the back is of great value in empyema cases that have been treated by the "closed method." The pocket serves to hold the rubber catheter between irrigations.

In eczema cases, to prevent the child from scratching the affected areas and also to cover the lesions, any one of the various cuffs and masks are of service.

The number of children to be taken care of by one nurse is an important problem. The ideal way is to have one nurse for each sick child. In practice this does not work out well, at least not in ward cases. Endeavor should be made to have as few children as possible handled by one nurse. Five patients should be the maximum number.

Training of nurse maids serves a double purpose. It eases the work of the regular nurses and trains girls to take care of infants at private homes. Training of nurse maids should be encouraged in every hospital for children. The pupils should, however, be made to know their place, to work under the supervision of the physicians and nurses. They should do only the work prescribed for them.

Ward helpers are a necessity and should be supervised by a nurse. They should be taught to clean the floor by mop and not by duster.

It is the duty of all people connected with a hospital to prevent contagion. This can be done: By aseptic nursing; by special observation wards; by vaginal smears; by nose and throat cultures; by examination for rashes.

Infants do not have to be segregated. Older children, especially over five years of age, should be segregated.

One of the most important problems in a hospital for children is how to make children eat. Even at home many youngsters do not eat; at the hospital the matter is even worse. In a study

made by Rena S. Eckman* and the author, it was found that the secret of success in the feeding of children is supervision during feeding. Children under five years may have to be fed by the nurse or ward helper. Older children should be supervised during the feeding period. In stubborn cases, quantitative feeding, where the quantity of each article of food is prescribed for the child may have to be resorted to. Of course, the food served to the children should be made as palatable as possible.

Visiting should be limited not only in contagious cases, but in all other cases. Visitors frequently bring in contagion and they also disturb the child's rest. Of course, parents and relatives feel that they have a moral right to see the child, and it seems unfair to exclude them at the time the child is critically ill. However, as soon as the child is out of danger, visiting should again be restricted.

It is hardly possible to exclude parents from visiting their children in a private room. In fact, some relative may have to stay with the child in the private room unless there is a special day and night nurse on the case. Leaving the child alone in a room by himself may be disastrous.

However, children who are in a large ward should be visited as little as possible. It has been found that children become restless and very often cry after visitors leave them.

Visitors should wear gowns while in the ward and should wash their hands with soap and water before and after their visit with the child. It goes without saying that under no circumstances should children be permitted to visit in a ward as they may carry infection or become infected themselves.

Social Service Department Needed

Every hospital for children should have a social service organization or at least one social worker to investigate the home conditions and to report to the physician in charge. The living conditions of the patient may have a special bearing on the etiology of the disease and on the treatment thereof.

Social work is especially important in making a decision as to the length of time the child should remain in the hospital. If the home conditions are good, the child's stay at the hospital may be shortened. If, on the other hand, the home conditions are poor or there happens to be another sick member in the family, the child's stay at the hospital may have to be lengthened.

Social workers should also be intrusted with the task of acquainting the family with what the

hospital is doing for the child. The social worker should be a sort of an intermediary between the hospital and the parents.

The follow up work after the child has left the hospital should also be left with the social worker.

The treatment of a sick child is not complete with the drop in temperature. The ideal way is to send all children who are recovering from a disease directly home, or to a convalescent home.

One of the most difficult problems in connection with convalescence of sick children is how to keep the child quiet in order to avoid complications and yet occupy his mind. A grown up person may indulge in reading. A child under ten years of age cannot read, or tires of it quickly. Toys have been used extensively. Children, however, tire of toys quickly.

Occupational Work Should be Prescribed

Occupational therapy carried on by a trained worker has rightly gained a place in children's hospitals. The difficulty, however, is how to choose the right play—call it recreation or occupation—for the patient. It is important to have the physician order in writing the type of play he wants the particular patient to have.

Pediatricians have come to realize the importance of breast milk for all infants and especially for infants suffering from diarrhea. Not all mothers can supply breast milk to their babies, and wet nurses are therefore employed in many hospitals for children.

In selecting a wet nurse, her previous history should be determined as much as possible, especially with reference to her character. A physical examination and a Wassermann test should be made on every applicant.

Wet nurses must be supervised, especially during the time they pump their breasts. Some wet nurses are quite apt in the art of milk dilution. They should also be supervised in regard to their food and the amount of rest they take.

An out-patient department is a necessity in a children's hospital. It makes it possible for the children of poor people, who are not sick enough to be in a hospital, to receive medical care. In addition it serves as a "feeder" of interesting cases for the hospital.

Teaching should be considered one of the functions of every hospital. A hospital for children offers two opportunities for teaching—the training of interns, nurses, and outside physicians in the art of treating children, and the teaching of mothers how to take care of their infants and children in health and in disease. In short, a hospital for children should also be a health center.

*Formerly dietitian, Michael Reese Hospital, Chicago.

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PROBLEMS INVOLVED IN THE GRADING PROGRAM*

By May Ayres Burgess, Ph.D., Director, Committee on the Grading of Nursing Schools, New York.

HOSPITAL superintendents and hospital directors of nurses are probably more vitally interested in what the grading committee is going to do than any one else in the country. They watch every move we make with anxious scrutiny, they weigh our lightest utterance with mingled hope and alarm, because everything the grading committee does is bound ultimately to affect the hospital administrator's job. We may help, or we may hurt; but we are certain to do something.

The Committee on the Grading of Nursing Schools has been organized under the joint leadership of the American Medical Association and the National League of Nursing Education, as a joint committee representing the medical, surgical, hospital, public health, patient, and nursing groups, to make an intensive cooperative study of nursing service. It takes its name of "Grading" from the original plan which hoped by "grading" nursing schools to raise their educational standards. That plan, however, is now being viewed in its wider aspects, and is seen to include not only problems of grading, but problems of nursing shortage, supply and demand, of types of service, of distribution and of costs. The work is just started.

If the present plans of the grading committee are followed, it seems probable that we shall begin this winter to make a careful nation-wide study of schools of nursing. We shall not attempt at this time to evaluate what the schools are doing

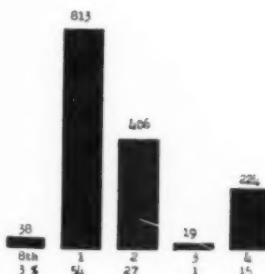


Diagram 1. Nursing schools requiring eighth grade, or 1, 2, 3 or 4 years of high school for entrance. 1,500 schools; 1925.

—to decide which schools are doing poor work and which good work, which schools are below standard and which above—because the committee believes that no one knows enough at this time to establish any standards for judgment. It would be comparatively simple, of course, to study the ten or twenty largest and most famous schools in the country, draw up a schedule of requirements based on the best practices of these lead-

*Read before the American Hospital Association, Atlantic City, N. J., September 30, 1926. Released and publication authorized by the association.

ing schools, and suggest that all the other schools ought to conform to them.

The grading committee is not going to work that way. It believes that it is not enough to know what a few leading schools are doing. There are over 1,500 schools in the United States. They are of widely different kinds, in widely different places, and they are playing widely different roles in their communities. Whatever standards for grading are finally adopted must conform not to



some ideal state of things, but to conditions as they actually are. Before a standard can properly be urged upon the nursing schools of this country, we must know not merely how it would affect this school or that school, but just what effect it would probably have upon the entire 1,500. Now the fact is that no one knows, really, what the nursing schools of this country are like. Some remarkably fine studies have been made, but they have dealt only with a few cases, while we need to study all the cases. We need to have a clear picture of the whole set-up before we can go ahead with any constructive thinking.

During the past few weeks we have made a preliminary study, as the first step towards getting this general picture of what the schools are like. The American Nurses' Association every two years publishes a pamphlet giving a list of all the nursing schools in each state that have been accredited by the board of examiners of that state. The reports from which this directory is compiled are sent in by the individual schools and contain not only the name of the school, but considerable additional information. The American Nurses' Association was kind enough to place its files for 1925 at our disposal, and the diagrams in this article are based on that material.

Diagram 1 relates to educational entrance requirements. There are 1,500 schools of nursing accredited by state examiners. Of these, 38 require student nurses to have finished the eighth grade of grammar school, 813 require one year of high school, 406 require two years, and so on.

The diagram shows that most of the schools have a minimum requirement of one year of high school. It has sometimes been suggested that no school ought to be placed on an approved list unless it requires a full four years of high school preparation. If that standard were enforced at the present time only 15 per cent of the schools could pass it and 85 per cent would fall below. In thinking about these figures it should be borne in mind that they represent minimum requirements. There are probably many schools that require one year of high school and yet get most of their students from the two, three and four year group. Just what is the educational background of senior students is a question that the grading committee hopes to answer later.

One question in this connection relates to the student turnover. In many schools apparently from one-third to one-half of all the probationers admitted either quit or fail before finishing the course. These student losses are expensive. It costs the hospital a considerable sum to carry the student through her first months of training, and during those early months she isn't worth very

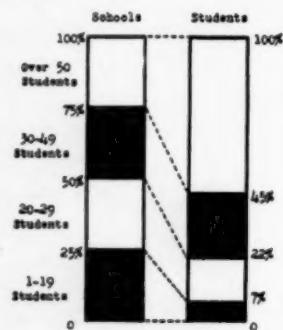


Diagram 3.
Per cent of
total student
nurses in each
25 per cent of
nursing schools; 1925.

much to the hospital in terms of nursing service. For that first period the probationer probably gets more than she gives.

If a hospital is short of funds—and most hospitals seem to be perpetually short of funds—it would seem the part of economy to refuse admission to those students who, experience shows, are most apt to drop out before the course is completed. The question, then, which this diagram raises and which in another year the grading committee ought to have means to answer, is, "Is there any connection between low educational preparation and failure to continue training? If there is, could hospitals save money, and still graduate the same number of students, by slightly increasing the entrance requirements?" No one knows the true answer to these questions, but it seems clear that the answer is worth hunting for.

Diagram 2—Student nurses. There are 104 nursing schools in this country where the entire student body is 9 students or less. There are 336 other schools where there are from 10 to 19 students, 334 schools with 20 to 29, and so on. In

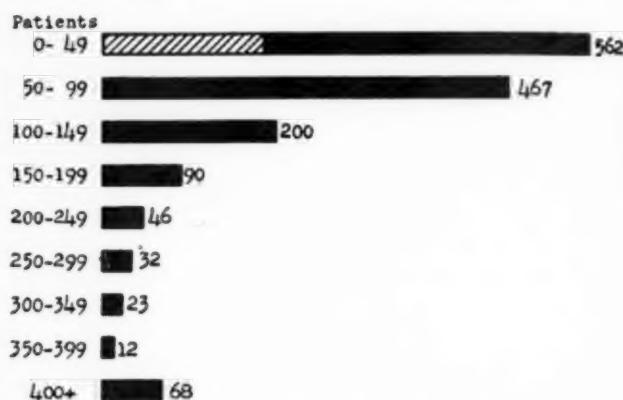
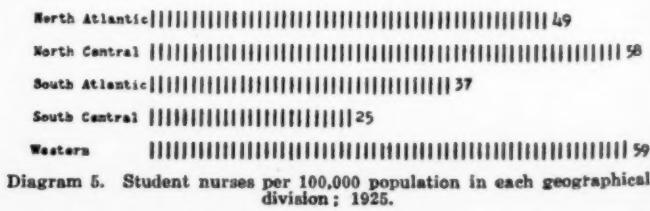


Diagram 4. Nursing schools attached to hospitals having a daily average of 0-49 patients; 50-99, and so on. Shaded portion shows 185 hospitals (or 12%) where daily average is less than 25 patients.

other words, considerably over one-fourth of all the schools have less than 20 students; half of the schools have less than 30; three-fourths have less than 50, while the remaining one-fourth have more than 50 students each. Most of the nursing schools in this country are small, and over a fourth of them are very small. And while there are some interesting exceptions, it is in general true that the very small school is attached to the very small hospital.

The question has been raised whether students who attend the very small school, attached to the very small hospital, are getting the broad general experience and thorough training that is the essential basis for good nursing service. It would seem an extremely expensive matter for any hospital to run a school with less than twenty students and yet provide for them the supervision, the laboratory facilities, lectures, demonstrations, and especially the broad, carefully guided clinical experience not only with surgical, but with medical, pediatric, obstetric and contagious cases, which medical and nursing leaders apparently agree is essential to good basic training.

There are small hospitals and nursing schools that manage to give all of these things, and as a result do a remarkably fine job of teaching nurses. It does seem, however, that the expense of running a really efficient school on so small a basis must be excessive and beyond the means of the very small hospital. One wonders whether in most of these cases the students are either not getting the sort of experience they need if they are ever going to work in larger hospitals, or, if they are getting adequate training, whether the school doesn't cost more than it can afford.



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Diagram 3. Another way of looking at the problem is this: If we imagine all the schools piled one on top of the other, with the little ones at the bottom and the big ones at the top, we have the same story as before. At the bottom of the column are one-fourth of all the schools. They are the little schools. Some of them have only three or four or five students apiece. None of them has as many as twenty. In the next



Diagram 6. Nursing schools reporting each length of working week for students on day service; 1925.

quarter come the schools with from twenty to thirty students, in the next thirty to fifty, and in the top quarter are the largest schools of the country—those that have over fifty students apiece.

Now if a cyclone should suddenly sweep the country, and by some inexplicable freak of nature wipe out of existence the schools that are in the lowest part of this column—all the little ones, that is—it would destroy 25 per cent of all the schools, but only 7 per cent of all the students. If that cyclone should wipe out of existence all of the very small schools, it would have hardly any perceptible effect upon the annual supply of nurses. There would be practically just as many new graduates as ever. If, on the other hand, the cyclone should destroy not the littlest schools, but the biggest schools, wiping one-fourth of all the biggest schools out of existence would remove over half of all the students that are now enrolled in the total number of schools throughout the country.

This diagram leads to some interesting specula-

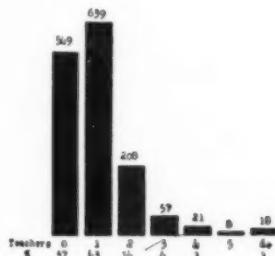
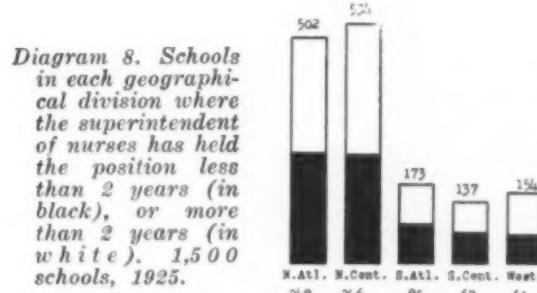


Diagram 7. Schools having no teachers or 1, 2, 3, etc., teachers respectively, 1925. ("Teacher" in this diagram means someone whose principal activity is teaching students.)

tion. Small schools are for the most part attached to small hospitals. Most of the schools in this low group are attached to hospitals with a daily average of less than fifty patients, and this includes, of course, private patients and convalescents. One of the frequent complaints of the hospital superintendent and the superintendent of nurses is that when the hospital tries to hire graduate nurses to help on ward service, it finds that they are apt, many of them, to be shockingly

incompetent. Some of them have come from hospitals so small that they have never had any real experience with ward work, and they are lost when they get into a big institution. It has been suggested that this 7 per cent of students, at the foot of the student column, may be the source of much of the prevalent feeling that nurses are incompetent. They are small in number, but it seems rather likely that they circulate rapidly from place to place, and so give the impression of being very bad and very numerous. It may be that if some method could be worked out for taking care of that 7 per cent, the hospitals trying to employ graduate nurses would find themselves relieved of much of their present dissatisfaction in this respect.

So far as the nursing shortage is concerned, this entire group of tiny schools could be wiped out of existence without making any appreciable change in the annual supply of nurses. But before doing anything that would tend to eliminate



the extremely small school, there are several other questions that must be faced and a solution sought.

First, is the small school meeting a real need? Is the little hospital to which it is attached serving the local community so well that anything that hurt the hospital would be a disaster; and is the hospital genuinely dependent upon its training school for its supply of nurses? If so, the hospital should be urged, not to close its school, but either to amalgamate with some other school, or to raise its own educational standards by hiring skilled supervisors, supplying adequate equipment and providing for affiliation, so that its graduates could go out not as incompetents but as high-grade workers.

It seems clear that no hospital should be encouraged to run a school unless it can give reasonable assurance that the graduates it turns out upon the rest of the medical and hospital world are well enough prepared to do at least passably good nursing. Yet the cost of conducting a good nursing school is proportionately much higher for the very small hospital than for the larger one. All of the schools in this lower quarter ought to

be carefully scrutinized to see whether they are really needed, whether they can be brought up to a reasonably good standard, and whether the hospital can afford to maintain them.

The second lesson to be learned from this diagram is that most of the student nurses in this country are being educated by a comparatively small group of schools. The large schools in the top quarter account for more than half of all the students. In other words, the large schools pretty much control the supply of nurses. If their methods are wise, the nurses will be competent; but if they are making any serious mistakes the results will spread all over the country. This means that we must not assume that because a school is large and famous and powerful it need not be carefully studied. It must be carefully studied, because of the very fact that it is large and powerful.

Small Schools in Small Hospitals

Diagram 4. We spoke a few minutes ago of the fact that while there are exceptions the small schools are, in general, connected with small hospitals. There are 562 schools—that is well over a third of all the schools in the country—connected with hospitals where the daily average is less than fifty patients for the entire hospital, and that figure includes private patients and convalescents. The black and white portion of the bar shows 185 hospitals or 12 per cent where the daily average is less than 25. There are 467 hospitals where the daily average is between 50 and 99; 200 between 100 and 149, and so on. More than one-third of the schools, that is, are connected with hospitals where the daily average is less than fifty patients, and two-thirds where it is less than one hundred. In view of the necessity for providing adequate clinical material if students are to have the broad background of experience they need these facts seem worth taking rather seriously.

Diagram 5 shows the number of student nurses per 100,000 population. In the North Atlantic states there are 49 nurses for every 100,000 people, in the North Central 58, in the South Atlantic 37, in the South Central 25, and in the West 59. The western states have more than twice as many student nurses in proportion to their population, as the South Central states have in proportion to their population. The chief use of a diagram like this is to raise questions as to why student nurses seem to be so unequally distributed; and whether the supply of graduate nurses makes up the deficiency; and if not, why not. The chief moral of this diagram is that different parts of the country have different problems, and any grading

scheme must take all parts of the country into account.

Diagram 6 shows how many hours the student nurses work each week. From 25-34 hours are reported by two schools; from 35-44 hours by 23 schools; from 45-54 by 59 schools, etc. Hours are slightly longer in the South and shorter in the West, but the average for the country is 55. This diagram is interesting because we can compare the length of the working week for student nurses with that for other occupations. Stenographers in most offices work 38 hours a week; factory workers from 40 to 48, with most of them nearer 40; ununionized day labor works about 48 hours a week. Probably the only large group outside the hospital that works more than a 48 hour week is domestic servant groups, which is probably one of the reasons why we have a domestic servant problem. The fact that practically all other forms of labor have adopted the short working week is something that probably has a pertinent bearing on the hospital and training school problems. In the light of what seems to be a constant drift of good nurses away from institutional nursing and into public health nursing, it is probably worth noting that public health nursing organizations, according to figures recently collected by the census of the National Organization for Public Health Nursing, have an average working week of 42 hours.

Duties of Teachers

Diagram 7 shows the number of schools having teachers. If we define a "teacher" as some one whose main job is the teaching of students, we find that there are 549 schools, or 37 per cent, which do not have any teachers at all; 639 have one teacher; 298 have two, and so on. No one would deny, I think, that some of the best teaching, of the most worth while type, that comes to the student nurse is done by people who would not be shown in this diagram. It is done by doctors who give lectures in the classroom and especially by those who give concrete explanation and discussion on the ward. It is given by superintendents, head nurses and often by the senior students themselves. The teaching that these people do is real and significant. Nevertheless, the fact remains that they are not hired for the purpose of teaching. Their main jobs are medical or nursing or administrative; and whatever teaching they do must be subordinate to their other work. Yet if there is to be a real school, in which the most important job on hand is teaching students and not merely providing service to a hospital, it seems safe to say that there should be some one on the staff who should give most

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of her time to the job of running a school—of teaching students.

I showed this diagram to one of the leaders in nursing education, who, when she saw it, exclaimed, "How splendid!" I suppose I looked a little taken back because I hadn't thought it was splendid, for she went on to say, "Ten years ago the first column would probably have been twice as high and the second column would have been almost empty. We really are improving!"

Diagram 8. In the North Atlantic states there are 502 nursing schools. Of these 248, or almost exactly 50 per cent, have changed superintendents within the past two years. This proportion holds just about the same all over the country. In the North Central states 46 per cent of the schools have changed superintendents, in the South Atlantic 50 per cent, in the South Central 50 per cent, and the West makes the best record, with 40 per cent. Moreover, conditions are probably even worse than these figures would indicate. We have taken account of only one change for each school during the two-year period; but we know that there are many schools that have had two or three superintendents within the period. I recently heard of a training school that has had seven different superintendents within the past twelve months.

An educational friend, the other day, on seeing this diagram, commented: "I don't know anything about nursing schools, but I do know just by looking at that diagram that something is seriously wrong with them. No system of education can possibly be in a healthy condition if half of its leaders quit their jobs every two years." That stands to reason. It takes longer than two years to build up a worth while school. Every change of superintendents disturbs the existing machinery; and if those changes come often, there is little chance to develop anything of permanent educational value.

Two Reasons for Turnover

There seem to be two chief reasons back of this excessive turnover. The first and most important apparently is that there is a serious shortage of properly trained superintendents. That is not the fault of the superintendents. There is no way in which they can get adequate professional preparation for the job. While we have no accurate figures, it seems probable that most of the nursing school superintendents in the United States have had two or perhaps three years of high school, three years of training school, and a few months as head nurse on a ward or in the operating room. They have had no direct training for the job of superintendent,

except what they have acquired on the job itself.

It is worth while to compare the education required to be the head of a nursing school with that required to be the head of a high school. The nursing school superintendent must be a graduate nurse. In addition most hospitals require at least a few months of duty as head nurse. They do not require the completion of high school or college. They do not require any professional graduate study whatever. Almost any bright student can become a superintendent of nurses, if she has done a little supervisory work and is willing to start in a small school. Once she gets her start, she can keep on going indefinitely.

Different Local Requirements

The principal of the modern high school has to meet different requirements. No bright boy or girl can hope, by finishing high school and then helping around for a few months, to step into the office of principal. The high school principal of today, with a few exceptions, has finished high school, finished college, had some teaching experience, and then gone to one of the big professional graduate schools, where he has taken either his A.M. or his Ph.D. He has spent two or three years in postgraduate work, studying the technique of running a high school.

Now, running a training school for nurses isn't a simple job. If the high school principal needs to spend two or three years after he leaves college in studying educational administration, it would seem reasonable to expect that the training school principal—who, like the high school man, is charged with the responsibility of running an important and highly complicated branch of a big business—ought also to have some definite professional education for her job. Most superintendents of nurses work hard. They give freely of all the energy and intelligence they have. They would be the first to acknowledge that they need much better preparation than it has been possible for them to get, if they are to live up to the possibilities of their jobs. Probably the chief reason for the 50 per cent turnover of superintendents is that the task is too difficult for them to handle without a broader professional foundation than it has been possible for them to secure.

The other reason for this tremendous turnover is that the job of being training school superintendent is not particularly attractive. Most of the salaries are too low. Worse than that, the superintendent holds two jobs; she is supposed to run a school, but she is also supposed to furnish nursing care to the hospital. The two jobs not infrequently clash and every time they do, the superintendent bears the brunt of the collision.

Even worse than that, the superintendent carries heavy responsibility but not proportionate authority. Often she has no direct access to the hospital board. Often she has no educational advisory board of her own. Usually she has no control over the funds spent for her own school. The job of being superintendent of nurses is so difficult that only a high-grade, experienced woman can handle it. There are so few of these high-grade women that hospitals are always competing for them. Therefore, unless the hospital is willing to reorganize the position and vest it with sufficient authority and independence of action so that it will be a really attractive job, it needn't hope to hold a competent superintendent. She won't stay. She doesn't have to. She can get another job.

Probably the biggest contribution that hospitals could make to nursing education would be to cut down this 50 per cent turnover of superintendents; but to do this they must, first, help to devise some method of advanced professional training of a solidly practical sort, so that there will be a bigger supply of competent candidates; and, second, make the position of superintendent of nurses sufficiently dignified, and with sufficient pay and authority, so that when the hospital gets a good woman it can keep her.

In conclusion, let me sum up this discussion by telling you what the typical nursing school is like:

It is in the North Central states.

It requires one year of high school for entrance.

It has twenty-eight students.

It is attached to a hospital.

The hospital has a daily average of sixty-five patients.

Students work a fifty-six hour week.

The school employs one full time teacher.

Its present superintendent has been on the job for two years and has just presented her resignation.

TRUSTEES, TAKE NOTICE

[Very pertinent to the position of the trustee to the hospital is the following letter that has been received and which was evidently written on the last day of the Atlantic City meeting. Unfortunately the superintendent wishes to remain anonymous.—Editor.]

"This is the closing day of the twenty-eighth annual convention of the American Hospital Association. None has been more successful and few have been comparable in the importance of the subjects discussed and the interest shown. But to me there has been one ever present regret. No member of my board of trustees was here to sit with me, bear and discuss with me these many important papers and discussions as they came hot from the bat. And I have a fine board, none better in the land and none more interested in its hospital. But get the

members of this board here I could not and did not after campaigning for that purpose for many weeks. Next year I must have one or two of them with me and I am asking THE MODERN HOSPITAL and everyone of its readers to aid me.

"We have a building program on the way, gathering weight for a launching; we are in the thick of a fight to get what is due us from industrial accident cases; we are reorganizing our training school; we are beginning to feel the need of special accommodations for the patient of moderate means. I may take back a report on each of these things and I may get some of my board to read it. When the annual report of the convention comes out months hence I can mark certain parts of it for my board's special attention but it will be cold gravy then and will have lost much of its value.

"How much I should like to have them with me, walking through the exhibit booths, meeting men enthusiastic about a device or a commodity for the better care of the sick! What a treat it would be to introduce them to executives who have spent their lives in hospital work and have loved every hour of it. I know what they have missed in missing these things but how am I so to impress them with what they have missed so that they could not be induced to miss it next year?

"There is no greater work in the world than running hospitals, that we know, but how much greater the work and results might be if we could get our trustees out to conventions, sharing with us their pleasures and profits."

A Superintendent.

DISTINCTIVE TYPE OF ARCHITECTURE MUST BE MODERN

Whether or not hospitals should develop a distinctive type of architecture is being seriously considered by the prominent hospital architects of the country and this subject was one that received interesting comment at the construction section of the recent Atlantic City meeting of the American Hospital Association.

No definite type of architecture seems completely fitted to the needs of hospitals, according to the opinion expressed by the leading architects, but there are certain improvements in modern construction and architecture that should be combined into a pleasing and practical type of architecture for hospitals.

Speaking of a distinctive type of architecture and the elimination of the institutional appearance, Richard Resler, architect, New York, says: "In order to eliminate the institutional appearance and to obtain hospital buildings of beauty and dignity, must we resort to copying a particular style of architecture, such as the Roman, Greek, or Italian, which was honestly developed centuries ago to meet local limitations in construction and materials, but which now entails endless adjustment of efficiency and appearance; and costly subterfuges?"

LABELING INFANTS

The necessity for extreme care in the labeling of infants and the checking of names to identify the patients at the moment of the delivery of the babies to their mothers was emphasized by the recent exchange of infants in the maternity department of a hospital in New York. Although the error was speedily rectified, the experience of the two mothers might justify the addition of another form of identification to augment the large number already in use.

BRINGING HEALTH AND HAPPINESS TO BULGARIAN PEASANTS

By Hazel A. Goff, R.N., Director, Bulgarian Red Cross School of Nursing,
Sofia, Bulgaria

TUCKED away between the Balkan Mountains and the Black Sea, in the southwestern part of Europe, we find a small country about the size of Ohio, with a similar population of approximately 5,000,000. In America little is known of this sturdy, thrifty country except political difficulties, tales of uprisings, bolshevism and the refugee question.

To appreciate Bulgaria, one must live there, drive through the countryside and see the rolling green fields of grain, the mountain sides dotted with flocks of sheep, sturdy peasants cultivating the lands with yokes of white bullocks or black water buffalo, the valleys, sweet with the perfume of roses and the huge baskets of luscious cherries and white strawberries being brought into market. Boy and girl scouts hike through the villages, bringing home armfuls of lovely wild flowers, fleurs-de-lis, forget-me-nots and violets. The village gardens and outdoor cafés are filled with men of all classes, joking over their shiskibob and beer or Turkish coffee.

This is real Bulgaria, populated by a fine, clean, hardy, honest, peaceloving people, interested in all new things, most appreciative of education, struggling to pay her debts and establish a firm government. Hampered by lack of money, the invasion of bolsheviks and heavy reparations, she struggles bravely on and if perseverance has any value, she will win.

Free Bulgaria has existed less than fifty years. Previous to that, for over five hundred years, she had been dominated by the rule of the Turk.

Fifty years is a short time in history for a country to become established, and unfortunately the past fourteen years have been a series of wars for this small state. Being involved in so many wars, we naturally wonder how she cared for her wounded and what the status of nursing was during that period. Until 1890 it was nothing. Under Turkish rule, with the complete subjugation of women, everyone lived up to the old slogan "God cares for the sick and the wife for the home."

Practically the only good feature we find in war is that it often makes for progress in the sciences. This was true in Bulgaria. War created there a demand for doctors and nurses and developed medical science. Until recently all the doctors in the country received their medical education in Russia, Germany, Austria or France. They were well trained and the medical profession in Bulgaria as in other countries is one of the most highly respected.

In 1918 a medical school was organized in connection with the university, under the auspices of the superior medical council and the department of public health, supported by government funds. At present about five hundred students are enrolled, 15 per cent of whom are women, and to date about one hundred ten doctors have received their degrees.

We find comparatively adequate provision for patients as far as hospitals and personnel are concerned, with the exception of nurses. The hospitals, however, are poorly equipped and organized. A year ago there were ninety-seven hospitals

in the country, including sixty-eight state hospitals, with a total bed capacity of 5,860. During 1924 in the state hospitals 100,388 patients were treated, with an average of eleven days per case and at a cost of seventy-five leva, or fifty-three cents per day. The same year's records show that 1,290,843 cases were treated in dispensaries and out-patient departments.

On January 1, 1925,



Bulgarian Red Cross Hospital, Sofia.



*School for
nurses, Bul-
garian Red
Cross, Sofia.*

the health personnel consisted of 1,166 doctors, 226 dentists, 1,227 midwives, 1,735 feldshers and 165 nurses. Experienced people have only to glance at these figures to appreciate the position of the nurse.

All state employees are classified according to education and importance of position and are paid and treated accordingly. Until March, 1926, nurses were classified lower than midwives and feldshers, in the category with the servants, and then people wondered why intelligent young women were not inspired to undertake the noble profession of nursing the sick as their life work.

Feldshers are men with a certain amount of training or experience in first aid and may be compared to orderlies. These men are turned loose on the public; some are good, some are bad, too often they belong to the latter class. Fortunately they no longer are appointed, though doubtless at one time they met a certain need in the country.

The training of nurses began before the training of doctors. In 1900,

Sister Efrosina, of the Russian Obshtina of the Holy Trinity, at the invitation of the Bulgarian Red Cross, came to Bulgaria with an assistant, to train young women to care for wounded soldiers in time of war. Up to this time no organized effort had been made to train nurses though there were some in the country. The first class of seven graduated in 1901 and the Russian sisters returned to their own country. The succeeding classes were instructed by the first group, with the aid of various doctors.

This first school was modeled after the Russian Obshtina, in which the head of the school controlled all graduates as well. The same home provided for students and graduates and was used as a convalescent and vacation home for graduates throughout the country. The Bulgarian School at Sofia was known as the Sveti Troitza Obshtina of the Bulgarian Red Cross.

In the early days of the Obshtina there were but eight beds for patients in the same building as the nurses' home, so that most of the nurses' experience was obtained in Alexander Hospital, the large, general, state hospital situated nearby. During the twenty-three years that the school was maintained according to the plan, there have been 274 graduates, about half of whom are practicing throughout the country today.

Directly after the Russo-Japanese War, the late Queen Eleanora of Bulgaria, became keenly interested in modern nursing. She had taken a nurses' course at Rudolfiner Spital, Vienna, before her marriage and had served with a hospital train in Russia. The Queen, who read all the leading German, English and American magazines, was well versed on the subject of nursing. It was her dream to establish a modern school in Sofia under the supervision of an American nurse administrator for four years, and meantime to train



En route to market.

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four young Bulgarian women in American hospitals to carry on the school upon their return. Plans for this project were well under way and Helen Scott Hay had been selected as director of the school when the World War broke out and negotiations had to be discontinued for the time.

Later, in October, 1914, Miss Hay, who had been in Russia, was authorized to visit Bulgaria and when she and her assistant, Rachel C. Torrance, were met by the Queen, it was arranged that they should immediately open the much discussed school in Alexander Hospital, Sofia, under her auspices. Just when the work was well started and success seemed in sight, Bulgaria's re-entry into the War made it necessary that the American Red Cross recall its nurses, and German sisters took charge. The school continued for some months but the military administration left little opportunity for its development. However, a total of twenty-four nurses graduated from the two-year course before the death of the Queen, after which public interest waned and although these young women worked bravely on with endless patience and courage they were not prepared to be the leaders in hospital and nursing administration for which they were originally selected. Several of these nurses have had supplementary postgraduate work since and are destined to make a marked impression on the nursing in Bulgaria.

In 1919-1920 negotiations to establish a modern school of nursing were again undertaken, this time by the Bulgarian Red Cross, with the result that Rachel Torrance received an appointment as director of the proposed school and returned to Sofia in October, 1922. Later Theodora Le Gros joined her and the modern school was formally opened under the Bulgarian Red Cross in March, 1923. This was a matter of reorganization and continuation of the original school directed by the Sveti Troitza Obshtina.

Problems of Nurses Many

The problems of these American nurses were many—differences in language, psychology and standards of nursing education and the humiliation of seeing faithful, experienced nurses constantly treated as servants. There were no doctors to support the project and the majority of the people lacked education on the advantages of modern nursing.

They were fortunate, however, in having a building of recent construction with painted walls, tile floors, sterilizing equipment, steam heat and toilets, though there was often great lack of water. A two-story building with two large open wards on each floor and several two-bed rooms provided medical and surgical departments for men and

women. A clean operating room on the second floor and a dressing room and septic operating room on the first floor, with a well equipped x-ray laboratory and three rooms for out-patients completed the layout of this institution, accommodating 120 patients, averaging thirty operations per month and thirty out-patient cases per day.

Here was the skeleton of a modern hospital, but essentials for nursing, such as medicine cabinets, charts, workroom tables, proper linen and food trays, were entirely lacking. Why, you ask? Because they had never had them, so did not miss them. The minority who had keen enough imagination to see the value of such things lacked the moral courage to demand them. One thing the American nurse must have in these countries is the courage of her convictions and my two predecessors had this. Consequently the Red Cross Hospital is now equipped with the necessary, simple, standardized equipment required to carry on all nursing procedures.

The hospital was staffed with five visiting doctors, one house doctor, nine graduate nurses and seventeen students who welcomed Miss Torrance when she took her official position. They greeted her with an address expressing their gratitude to the American Red Cross and presented her with a beautiful bouquet, but most unique was a gift of a loaf of bread and a dish of salt with instructions to carry them to her dwelling place.

*Graduates
of the Sveti
Troitza Ob-
shtina or
original
Red Cross
School.*



This is an old Bulgarian custom observed when the bride is welcomed to her new home.

The pension for the nurses is in the same attractive garden that surrounds the hospital. It is a fairly modern, comfortable building, which can accommodate sixty nurses, and has a classroom, a dining room, two offices, two salons and three baths.

The first step in the reorganization of the school was to secure more highly educated young women as nurses. This meant educating the public, and propaganda on this point still continues. The requirements were raised to a minimum of sixth class gymnasium, which is equivalent to two years of high school in America. The school was approved as a middle special school by the ministry of education in August, 1924, which means that graduates of the nurses' school are considered as gymnasium graduates in rating them for state positions and salaries. Gradually the applicants have been culled so that today the majority are graduates of gymnasium which more than equals the high schools of America. At present we have forty-seven students, practically all we can accommodate.

Complying with our new constitution of the past year, we are giving a three-year course. The first three months is a preparatory period with intensive theory and limited hospital duties and the last nine months is devoted to executive or special work in first-class hospitals in Sofia. The theoretical course of 585 hours compares favorably with that of the better American schools.

Practical Routine Not Different

The practical routine of the Red Cross Hospital, with its Americanized staff, is quite like any hospital in America, though necessarily simpler. A strict eight hour day and night is maintained. One sees a vast change from a short time ago. Then nurses felt obliged to be on duty only when the doctors were present in the morning; none but first year nurses soiled their hands with cleaning cloths; the house doctor taught practical nursing; medicines reposited on the bedside tables where patients could help themselves; patients slept in their clothes; supplies were given when the domakin or steward thought best and treatment orders were called from one end of the building to the other by the doctors. From this we have evolved into a congenial teaching institution. We have prompt, quiet doctors' visits, order books, regular change of linen, graphic charts and nursing notes which are improving, a medicine card system and no department is ever left without a nurse. All these things have produced system and interest in the institution resulting in better care of the patients.

We can give a satisfactory preparation in medical and surgical nursing but unfortunately we lack two fundamental subjects, pediatrics and obstetrics. The former has recently been provided for by a three months' affiliation at the University Children's Clinic and we expect similar arrangements will be made for obstetrics within a few months.

The training of students presents much the same problems here as in America. There are members of committees who do not understand what a nurse is; lack of funds for educational purposes; lack of interest in living conditions. In the hospital there is the usual story of no linen, cold food, a supply room that never supplies anything but excuses, and a house doctor who is never available when needed, as is common with house doctors.

Financial Straits Hinder Nursing

When you consider that people know less about nursing here than in many other countries because here it is a younger profession you expect progress to be less rapid. Added to this, the financial straits of the country hinder our work seriously as from now on we shall be developing the state hospitals here. In the Red Cross Hospital we have only the barely essential things but this represents but about 2 per cent of the hospital beds of the country. One feature we endeavor to keep constantly in mind is simplicity as well as efficiency in our practical work, so that these young women we are training may not become discouraged when they go to other institutions, upon completion of their training.

From this article I trust you have deduced that the doctors are, on the whole, well trained men, forced to work without proper assistance or equipment in most instances and quite dependent upon their personal resources, as state salaries are inadequate. The graduate nurses are few in number, though practical and efficient in emergency work. As for the new nurse, we are getting now the desirable type of young women and their efforts and interest will make an impression if we can train a sufficient number before discouragement overtakes them.

But what of the patients?

If you glance at your geography you will find the population is chiefly a peasant one and from this group of individuals the bulk of our patients are drawn. Most of them have lived a simple life and to them the hospital seems an intricate organization. When very ill they are usually brought to the hospital in a springless cart filled with straw and drawn by white bullocks or black water buffalo.

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Once here, the next problem is to remove their clothes, as most of them are accustomed to wear the same garment, which consists of layers of homespun, day and night. Recently we have standardized our hospital costume for both men and women to pajamas and a flannelette bath robe. This costume was a revelation to many and when the women were first initiated to it, they had as much fun as if we had given them a masquerade party.

Baths have been a continuous problem because of the great water shortage in the city. Sofia has outgrown its supplies in many ways and water is one of the commodities that is rationed. The officials consider us extravagant in this respect but that is because of a difference in point of view. At home we are accustomed to have and give daily baths with a moderate amount of water, while the weekly or monthly bath of the Bulgar peasant is a ceremony. There must be an unlimited supply of water for a tub bath, enough to cover him entirely while he scrubs, lathers, shampoos and soaks, then as much more water is required for the rinsing process. After bathing he wraps himself in a voluminous bath towel or havlea and rests in a warm place free from drafts or even fresh air. A draft is regarded with as much horror as an evil spirit and an "open window war" is constantly being waged in our institution by the supervisors. Others take their baths in concentrated form. The country is full of all types of mineral baths, both hot and cold, and these are very popular. In summer particularly women spend weeks at these baths, absorbing all possible benefits that will tide them over until the next season.

People Are Spartan

A few years ago I should have said patients were the same everywhere, especially the men who become such helpless babies when ill, but here I have encountered a different variety. These people can withstand the greatest amount of pain without flinching or uttering a murmur. A year ago, at the time of the cathedral disaster, when we cared for so many terrible injuries, I marveled at their tolerance. One would be tempted to say they had no nerves; they have every bit as many as we have but their endurance is remarkable. Morphine is not frequently used; instead we administer camphorated oil by the liter.

Personally I found much to learn about treatments when I first came. In fact I am still learning and find they have much to teach us. Some methods I have the greatest respect for, others I have adapted myself to. For instance, all temperatures are taken by axilla. In the United

States we look upon this as being the less accurate and less efficient method, so I watched, wondered and questioned. Now I have come to the conclusion that they are very wise. Where facilities for disinfection are limited and questionable and thermometers few, is it not better to risk an axillary temperature than one by mouth? Contrary to my early instruction I find a ten minute axillary thermometer registers the same as a one-half minute mouth thermometer.

Application of Compresses Popular

The application of compresses is a remarkably useful and popular treatment. This consists of a large, moist, cool cloth placed over the affected area, covered with thin rubber and then held in place with a binder or bandage and renewed every twenty-four hours. These compresses are used for every known complaint, sore throat, pleurisy, coryza, pneumonia, appendicitis, sprains and the usual infections. It has become a slogan among the nurses to say "When he is in doubt he orders a compress."

Cupping is so common that every old woman or "baba" in the country can put American nurses to shame by their skill in applying it. They produce the desired results too.

Little has been developed in a dietetic way in the hospitals. In the villages the diet consists largely of black bread, sour milk, garlic, onions and other vegetables, with mutton for the principal meat. In the city more meat is consumed as it is cheaper. Gavetch, which is a sort of stew of meat, potatoes, egg plant, tomatoes and peppers cooked with oil, is one of the most common dishes, while dried or green beans cooked in oil form another, and pilaf, a rice dish forms a third. Compote or stewed fruit and sour, clabbered milk are the chief desserts. Many red peppers, much oil and sour milk enter into all their dishes. The famous sour milk is held responsible for long life and is delicious, once the taste for it is acquired.

This is a land of many superstitions, numerous holidays and feast days, all of which add color to the simple, passive lives of the peasants. Many of the holidays are church days, when elaborate ceremonies are held. Even the nurses' graduation consists principally of a religious ceremony conducted by three to five popes, for this is a pro-Slav country.

Public health nursing is in its infancy here. There have been five child health clinics opened in Sofia and these are managed by a nurse who has had special training in England. There are now three other nurses working with her but it is slow, uphill work with little support as yet. A second nurse is studying in England this year and it is

expected there will be funds to expand the work in 1927. Even with this small beginning, many changes have been brought about in the poorer districts. The Rockefeller Foundation is preparing doctors for public health work by foreign study, but to develop the plans that have been made many nurses will be required.

We have solved the problem of the modern school of nursing but our space is so limited that only a few nurses can be prepared, while the need for them is urgent and extensive. Another school is our only salvation and this should be controlled by the state and should be in connection with the university. Logically this school should be in Alexander Hospital, Sofia, which offers all types of clinics and has a capacity of 1,500 beds. I have just visited the children's clinic here. Not one bed had a sheet or pillow case, all the patients were lying on the mattresses. Where was the linen? It had been sent to the laundry so it would be clean for Easter Sunday. There was not sufficient to change. What can be done about it? It is a state institution and the state has no money. What can we expect of our nurses who are forced to work under such conditions?

This is not propaganda for Bulgaria but a simple statement of facts. I know that few people in America know anything of this part of the world or how some of these small countries are struggling for existence. They need the interest and inspiration of more prosperous lands.

More State Funds Needed

In my opinion to meet the conditions mentioned above more state funds and more interest on the part of the public are necessary. This requires education of the middle-class person by means of extensive health propaganda that will reach, interest and appeal to him. We may touch the wealthy man's pride but how can we interest the peasant, who comes as our patient? Only through kindness and care. We watch the sullen, moccasin-footed, sheepskin-coated man leave the ward, never showing by the flicker of an eyelash his gratitude or appreciation. He pads out of the hospital after his appendectomy or typhoid, solemn, stolid, not daring to look at the nurses as he bids them "*dovejdene*" for fear he will betray his real feelings. He climbs on his little horse or donkey, from whose sides hang big baskets which earlier in the day had been filled with wool, spinach, cherries or cheeses, which his *jena* had taken to market in his absence. "*Heidie*," and the donkey trots off, the wife walking behind her good man. Neither speak as they plod along the dusty road to their home. Stephcho watches the sun sink over the hills in the west. Maria

waits in respectful silence. Later, at home, as he pulls off his socks by the fire we hear him exclaim, "Maria, we must plant that other patch of tobacco this year and raise more sheep for wool. The state needs money to take care of us when we are sick and to pay those nurses they are training."

STUDY MADE OF HOSPITALS FOR MENTAL DISEASE

The report of the census of hospitals for mental disease, conducted by the Federal Census Bureau, is now ready for distribution, according to *Mental Hygiene Bulletin*. This census includes resident patients in these hospitals on January 1, 1923, and the admissions, discharges, and death for the year 1922. It is the most comprehensive study of these hospitals that has ever been made, introducing the following features not to be found in previous reports of the Census Bureau:

1. Classification of resident patients, admissions, discharges and deaths according to the standard mental diagnosis adopted by the American Psychiatric Association and advocated by the National Committee for Mental Hygiene.
2. Separate data for first admissions and readmissions.
3. Data for ex-service men.
4. Data for psychopathic hospitals and psychopathic wards of general hospitals.
5. Data with respect to patients on parole.
6. Data relative to the administrative personnel of state hospitals.
7. Data concerning the value and acreage of state hospital plants.
8. Data on the cost of maintenance and other expenditures of state hospitals.

The institutions included in this report numbered 526, of which 165 were state hospitals, 148 other public hospitals for mental disease, and 213 private institutions.

This 257-page volume, entitled *Patients in Hospitals for Mental Disease, 1923*, may be purchased at thirty-five cents a copy from the Superintendent of Documents, Government Printing Office, Washington, D. C.

BRITISH HOSPITAL EXECUTIVES AND NURSES TO HAVE PENSIONS

It is expected that the scheme of pensions for hospital officers and nurses in England will be in operation by January 1, 1927, or possibly earlier, according to the *British Journal of Nursing*. Steps were taken last July by King Edward's Hospital Fund of London to start this scheme, which affects not only nurses in hospitals but in all branches of the profession.

The scheme is to include all female professional nurses, whether nursing the sick or doing work under a public authority. In its complete form it includes all probationers after one year's training but it will be open to each hospital to decide whether to admit probationers after one year's training or not until they are state registered as nurses. It is to be compulsory for all new entrants into the service of the hospital to join the scheme according to the period the hospital may have decided to adopt for the admission of probationers.

The total contribution is to be 15 per cent of salary and emoluments, the hospital to pay 10 per cent and the officer or nurse 5 per cent.

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Christmas Here and There

Above, natural Christmas decorations at the Modern Woodmen of America Sanatorium, Woodmen, Colo.; right, Christmas Morn in the Children's Hospital, Cincinnati; below, Yuletide decorations in the wards of the Hartford Hospital, Hartford, Conn.



HOW THE MEDICAL SERVICE OF A TUBERCULOSIS SANATORIUM SHOULD FUNCTION*

By Colonel David Townsend, M.D., Johnson City National Sanatorium, (Mountain Branch), National Home for Disabled Volunteer Soldiers,
Johnson City, Tenn.

THE balance of any organization whether it be large or small depends upon an efficient and workable correlation of its integral parts. This is true of a large tuberculosis sanatorium. As this paper deals only with the medical service no mention will be made of the general administrative service, which also is an important component of the entire organization.

The medical director and superintendent is the head of the institution, with a double responsibility: the determination of the medical policies and their promulgation and the general administration of the institution. He is responsible to his board for the proper functioning of his institution and the efficient care and treatment of the patients in the institution.

Under him and next to him comes the assistant medical director, who is in immediate charge of, and who has immediate supervision over, all the medical activities, subject to the approval and the direction of the medical director and superintendent. During the absence of the medical director and superintendent from the institution he assumes his duties.

The various medical officers assigned to the units for the care and treatment of the patients—the chief nurse with her assistants and the nursing staff under her supervision; the ward attendants and ward maids, responsible to the nursing service, medically, and to a chief ward attendant for their deportment and discipline—are all responsible to the assistant medical director and through him to the medical director, and

superintendent, or chief executive in charge.

The laboratory service; x-ray service; dental service; eye, ear, nose and throat service; surgical and genito-urinary service; occupational therapy service and physiotherapy service, in charge of their respective heads, responsible to the assistant medical director, and through him to the medical director and superintendent. Consultants—part time men—can be added to the various departments if deemed best, and should function according to the plan for the department to which they are attached.

The record and admission office with its various clerks, the druggist, ambulance drivers, undertaker or morgue keeper, mail orderly, as well as the various hospital stewards and employees utilized in keeping the institution clean, are directly responsible to the assistant medical director.

This institution has a twenty-four hour medical service, that is, there is a medical officer on duty in rotation for night calls, together with a night supervisor of nurses and night nurses, particularly in the infirmary unit.

Various recreations are supplied to the patients, including radio installation supplying all wards, moving pictures and music. These are arranged so as not to conflict with the treatment or the rest hours of which there are two—one in the morning and one in the afternoon, each of two hours' duration.

The various messes with their personnel are in charge of a mess steward or officer, who is responsible to the assistant medical director for their proper functioning. The immediate supervision of the messes including tray service is in the hands of dietitians, under the mess officer and with the cooperation of the assistant medical director of the institution.

*This is the second of a series of articles to appear in succeeding issues of THE MODERN HOSPITAL, dealing with the planning, equipment, organization and operation of tuberculosis sanatoriums and preventoriums. This series is prepared under the direction of Robinson Bosworth, M.D., superintendent, Rockford Municipal Tuberculosis Sanatorium, Rockford, Ill.

This article has been approved for publication by the president and board of managers of the National Home for Disabled Volunteer Soldiers.

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The administrative departments other than medical come under the executive officer, who is directly responsible to the medical director and superintendent.

It will be noted therefore that all the services that have to do with the medical care and treatment of the patients are responsible to the assistant medical director, and through him to the medical director and superintendent and the general administrative service is responsible through the executive officer to the medical director and superintendent.

One Officer for Fifty-five Patients

There should be not less than one medical officer for fifty-five patients and one nurse for twenty patients. The infirmary or sick unit will require more medical officers, nurses and ward attendants, in proportion, than the other units. This institution with a bed capacity of 1,146 beds has provision for a staff of sixty nurses in addition to the chief nurse and her assistants, and seventy ward attendants, giving an average of about one nurse and one ward attendant to twenty patients.

In order to insure the best results in a large tuberculosis sanatorium the unit plan should be adopted rather than one large building. In this way provision can be made for the various groups, infirmary, semi-ambulant, and ambulant, without one interfering with the other. This arrangement also facilitates the assignment of the patients to the units indicated by their physical condition.

The infirmary unit should have a bed capacity equal to about one-third of the total bed capacity of the institution. This will naturally depend somewhat upon the type of cases admitted. A greater bed capacity in the infirmary unit will be required if all stages are admitted than if only the incipient and moderately advanced cases are received.

The semi-ambulant and ambulant units come next in order. In this arrangement it is possible to create a stimulus in the individual to regain his health, as each step is in the nature of a promotion or reward for intensive effort, as each unit in progression carries with it increased privileges of greater freedom with less restraint. Naturally, however, there will be some patients who will relapse either through indiscretions or from other causes and they may have to return to the infirmary unit to begin all over again.

With the unit plan the medical officer in charge of an individual unit is in reality conducting a small complete sanatorium under the assistant medical director. He is responsible for the welfare and treatment of the patients under his

jurisdiction, also for the efficiency of his nurses and ward attendants, subject to the broad general policies promulgated by the medical director and superintendent for the efficiency of the entire institution. He is responsible for the physical upkeep and the general cleanliness of the unit. The infirmary unit will naturally carry several medical officers for its proper functioning. Each of the other units will carry only one. The success of each unit will depend upon the efforts of the medical officer in charge. It is possible with the unit plan to exert closer supervision with more favorable results. In order to insure the best results, the medical officer in charge of the unit should be the father, friend and confessor of those under his care. This personal, humane touch and kindly interest in the welfare of patients is what makes for success in the treatment of tuberculosis.

When patients are admitted they pass through the record or admitting office first. Here the statistical history is taken and the hospital index card made out. The patient is then sent to the admission or receiving ward. The record office makes up the morning sick report, the daily census sheet, which supplies a ready reference as to the location of beds, the number occupied and the number vacant in each unit, and admissions and discharges. The hospital records of all cases discharged are filed in numerical order. A card index file is kept showing those present, with their location, and those discharged. Each card bears the number of the record and these are filed alphabetically. The record of each patient in this institution is kept in the unit where he is located, so as to be readily accessible for consultation.

Procedure for Examination

From the receiving clerk the patient goes to the admission ward or unit, where he is weighed, unless his physical condition contra-indicates. His pulse and temperature are taken and he is put to bed for a period of observation in order that he may be correctly diagnosed and classified. This period is usually fifteen days. During his stay on this ward, his personal, medical and clinical history are taken and he is given a thorough physical examination, with x-ray, including chest, teeth, sinuses, laboratory tests of sputum, five in all, urine, blood Wassermann, as a matter of routine, complement fixation, erythrocyte sedimentation and Daranyi test. A dental survey is made when any defects found are corrected. An eye, ear, nose and throat examination and a surgical examination are also made for the detection of any surgical disabilities present or which have existed in the past.

The pulse and temperature are taken every four

hours during the day and the patient weighed once a week. A progress note is kept which gives a complete picture of the progress of the case. Nurses' observation notes are also made, giving an insight into the character of the case, a valuable adjunct in the treatment. All the findings of the various services mentioned above are entered on special record sheets for this purpose and become part of the patient's record. It is the aim of the admission ward to obtain as complete a record on each case as possible, in order that the treatment may be intelligently inaugurated.

At the end of the fifteen days' observation period, the patient is examined by a board of three medical officers, who, after careful consideration of all the data in the case, recommends the next step in his treatment. This recommendation is transmitted to the assistant medical director for his approval. All doubtful cases of diagnosis are referred to the assistant medical director and then to the medical director and superintendent if necessary.

The complete record of the patient follows him to the unit to which he is sent for further treatment. This procedure is followed in all subsequent transfers.

While the patient is in the admission ward he receives a pamphlet dealing with tuberculosis and is given instructions by the medical officer as to what the disease means, how to care for his sputum and what will be necessary in order to regain his health.

Each Medical Officer Responsible

The medical officer in each unit or ward is responsible for the care and treatment of the patients under his jurisdiction, for the proper records of each case and for the diets indicated in the various cases. He should also see that his unit is kept clean. In all of this he has the assistance of the nurses and attendants. The various special diets are ordered by him and approved by the assistant medical director and prepared in the kitchen under the supervision of the dietitian.

Each case is examined every two months, as a matter of routine, as long as the patient remains in the institution and more often if indicated. X-rays are taken every three months and sputum is examined every month. The patient is weighed once a week, and his pulse and temperature are taken regularly. A progress note is made on each case as frequently as is necessary to give a complete picture of each case. All the above findings are recorded on special sheets and become part of each record.

Upon discharge, whether it be before treatment or when treatment is completed, the patient is

examined by a board of three medical officers, having before them a complete survey of all the data. As an adjunct to treatment, occupational therapy and physiotherapy are utilized.

Special Tests of Laboratory

The clinical laboratory makes all special laboratory tests, in addition to routine, including basal metabolism, guinea pig inoculation and spinal fluids. It also makes daily examinations of the milk supplied to the institution, and a weekly bacterial count of it. Such postmortem work as may arise, including the examination of pathological specimens, is carried out by this service.

The eye, ear, nose and throat service supplies all routine treatments, a special hour being set aside each day for this purpose. This department also performs all operative work necessary for recovery. The surgical service is responsible for all emergency and other surgical work and gives venereal treatments.

The x-ray service in addition to routine examinations makes all special x-rays that may be required, including gastro-intestinal for suspected intestinal tuberculosis. This service also furnishes x-ray therapy where this is indicated.

The dental service in addition to the routine admission examinations furnishes all indicated adjunct dental treatment necessary for efficient mastication, so essential for recovery in tuberculosis, as well as all emergency treatment.

The physiotherapy service is utilized in all cases in which this treatment is indicated.

The occupational therapy service is employed in all cases save those too ill to undertake even the lightest form of exercise.

The cases in the infirmary unit, have a tray service for the bed cases and a mess located in the unit for those able to be up and about. The semi-ambulant and ambulant units have a mess.

Staff conferences of the medical staff are held daily, save Saturday and Sunday, when all medical and administrative questions pertaining to the medical work are discussed for the benefit of all. At least once a week clinical conferences are held on all doubtful cases, when a thorough discussion of the case is made by the entire staff.

To sum up, the entire medical service with its various adjunct services should be organized so that each department functions to the highest degree and dovetails and cooperates with the other services, thus making possible the complete correlation of all the data in each case. This correlation is essential for accurate diagnosis and proper treatment. The clinical records should be so complete that they offer an accurate picture of each patient during his stay in the institution.

STUDIES ON HOSPITAL PROCEDURES

THE HOSPITAL LABORATORY

General Statement: The hospital laboratory is the scientific heart of the institution. No other activity does so much to stimulate a proper scientific approach to the clinical problems encountered in any of the hospital departments. Not only does the maintenance of high postmortem percentage often depend upon the laboratory for its force, but also the conduct of clinical pathological conferences by the director of the laboratory and by clinicians from the hospital departments, provides a continual stimulus toward better and more modern medicine. The functions of the clinical laboratory in hospitals, irrespective of their size, may be stated as follows:

1. The performance of certain careful laboratory studies on all patients upon their admission to the hospital.
2. The examination of material from individual patients, which may be referred to the laboratory by the clinical staff in the course of the patient's residence in the hospital.
3. The pursuance of systematic surveys of the hospital's population, for the detection of pathologic agents, diseases and complications developing within the hospital, as well as the initiation and prosecution of occasional sanitary surveys of the institution, its appliances and the methods it uses.
4. The study of tissues obtained in the course of surgical operations, and the systematic examination of bodies of the dead for the purpose of confirmation or correction of diagnosis.
5. The instruction of interns and nurses and the pursuance of research, aimed to add to the general sum total of medical knowledge.

These functions are all performed to a greater or lesser degree, even in hospitals of but half a hundred beds possessing a clinical laboratory. In conformity with the requirements of the American College of Surgeons and the recommendations of the American Hospital Association, as well as with modern hospital practice, the institutional laboratory should have facilities for the performance of bacteriological, chemical, pathological, clinico-microscopic and serologic work. Most hospitals of 100 beds or more have provisions for

adequately performing the first four types of work mentioned.

Sometimes facilities for tissue diagnosis and serology are not at hand in smaller institutions, this work being referred to a state, municipal or private laboratory. This arrangement, when properly perfected, apparently meets the requirements of the American College of Surgeons, and while not an ideal one is oftentimes of necessity the plan adopted.

The Location of the Laboratory

It is impossible to make any conclusive statement in regard to the proper location of the hospital's laboratory. However placed, this department should be assigned adequate, well lighted and well ventilated quarters, so as to furnish not only ample room for the performance of present day work, but for future expansion as the needs of the hospital increase.

There appears to be a definite tendency in hospital construction to depart from the custom of placing institutional laboratories in the basement. From the standpoint of facilitating tissue work, it is sometimes felt wise to place the laboratory near the operating suite. But this does not seem justified for this reason alone, since tissue diagnosis is usually a minor portion of the total laboratory work performed. Nor is the apparatus required for this work, even though frozen sections are often requested, so bulky that it cannot be transported to the operating room whenever needed.

In many large institutions where ground is available the laboratory work is carried out in a separate and distinct building, designed for this purpose. In other institutions a whole floor is allotted to laboratory purposes.

If possible the laboratory suite should be isolated, in a measure at least, from portions of buildings devoted to the care of patients, because of the necessity for the presence of laboratory animals, with the attendant noise and odors. Reference is here made to the continual need for guinea pigs, rabbits, mice and frequently some of the larger animals, if research work is being done. Where a separate building is available the animal house is often on the top floor, balconies being used for outdoor runways.

There are two systems in use in hospitals generally, the adoption of either more or less determining the location, arrangement and size of the laboratory department. These consist of either the centralization of all this work in one location, or the performance of minor tests in a small work-room located in each hospital division.

Where all requisitions are made on a central laboratory, and a member of this department's

personnel visits the wards for the collection of specimens, the presence of these small ward laboratories is not essential. In other institutions it has been felt that while centralization of effort is a wise plan to adopt, the presence of small, well equipped laboratories on each department adds to the institution's efficiency, because of speeding up the return of requisitions for urinalyses, blood counts, gastric-analyses, etc.

With the refinement of medical effort, which has brought about the establishment in our hospitals of metabolic services and other similar departments, it has even become necessary for rather elaborate special laboratory facilities to be provided.

It would appear wise for the chief of the laboratory service to have at least nominal supervision over all laboratory effort in the hospital, and if special laboratories are to be established for hospital departments it would seem that, from the standpoint of administration, he should at least be responsible for maintenance of a proper inventory of scientific apparatus in these locations.

It cannot be disputed that time and effort will be spared by the placing of small laboratories at various sites throughout the hospital. In these laboratories minor procedures can be performed, the results of which are required at once. If this be the system adopted, however, the chief of the laboratory service should be held responsible for the accuracy of the work done therein, and for the proper filing of the results obtained. This subject will receive further discussion later in this article.

The Organization of Laboratories

It is absolutely necessary that the hospital's laboratory should be headed by a competent man or woman, preferably with a medical degree. Whether or not this officer will devote his full time to his work will depend largely upon the size of the hospital. In the case of smaller institutions, but a half or even less of the pathologist's day may be devoted to any one hospital. In some localities it is customary for a pathologist to render service to two or more hospitals, an arrangement that appears to be fairly satisfactory to all concerned. In his absence an associate or even a skilled technician is expected to assume responsibility for the hospital's laboratory work.

If the hospital in question is one of considerable size, oftentimes the five types of work mentioned above are performed in separate rooms or suites. From the standpoint of organization, each department may be supervised by a separate officer, or one man may have charge of two or more rooms.

Most state boards of medical education and

licensure require that a definite, well planned course of instruction in laboratory work be given to interns. These boards are usually not content with the intern's receiving instruction in the simpler tests, such as, urinalyses, blood counting, and gastric-analyses, but require some experience in blood chemistry, bacteriology, and even, in certain states, tissue work and the Wassermann reaction. It is customary to require out of the intern's service at least two months' experience in laboratory work. The director of the laboratory is often required to sign an efficiency statement at the conclusion of this service, certifying to the amount and type of work that has been performed, this certificate being presented to the state board before the intern is permitted to take his examination for license.

A definite rotation of service within the laboratory should be worked out, as is done for services in other departments. It is usually expected that the director of the laboratory will periodically issue a definite schedule relative to the intern's responsibility for the performance of night, holiday, and Sunday laboratory work in the hospital.

In very large laboratories a handy man or diener is expected to do much of the cleansing of utensils and glassware, and in some institutions even the preliminary chemical tests in the course of urinalysis are performed by this person.

Intradepartmental Relations

Even if the hospital laboratory be of small size a healthy esprit de corps should be developed and maintained among its workers. The holding of laboratory conferences for interns, technicians, and laboratory staff members, at which problems that arise in the laboratory's daily work are discussed, serve a good purpose in maintaining a high morale. The discussion of such problems as waste in the use of supplies and the need for the purchase of new equipment, should have a place in these conferences. Recent developments in laboratory technique, as well as occasional scientific presentations by members of the staff, may provide the scientific portion of these conferences.

A new trend in hospital work seems to be the elevation of the director of the laboratory to a position in which his services as a consultant will be sought by clinicians for the various hospital departments. In former years the chief of the laboratory was relegated to a position in which he dealt with materials from patients whom he never had an opportunity to study. Today the laboratory director is seen at the bedside of the patient, in consultation with the surgeon and physician.

The director of the laboratory is also useful to the superintendent of the hospital as an expert

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in studying and preventing hospital infections, defects in sanitation and contamination of water, milk or foods. In institutions where a chemist is available the examination of soaps and other cleansing supplies for fatty acids and insoluble residues, and of drug solutions, concerning which there may be some doubt as to the contents or purity, is of the greatest practical utility in the solution of such difficult hospital problems.

Finally, it may be stated that the laboratory head, instead of being isolated on the extreme edge of the hospital's scientific activities, and occupying the major portion of his time performing examinations on inanimate materials, has been brought into closer contact with the sick, to their ultimate good, as well as to the good of the institution generally.

One of the most difficult problems for the institutional executive to solve is the speeding up of responses to requests from the hospital wards for examinations of all sorts.

The delay in the institution of treatment or in the discharge of a patient, as a result of a failure promptly to secure information from the laboratory, is in the aggregate enormous. The mere collection of specimens is a small matter compared with some of the other difficulties that may arise before the report is returned to the ward. Nor has the adoption of a system of emergency or "stat" requests, with the use of separate or distinct forms for the purpose, solved this problem in any final way. A form for urgent laboratory requests is, of course, necessary. A form of a different color is often employed for this purpose, but the difficulty

arises in the misuse of this latter form, so that after a time it does not signify the need for speed.

Laboratory request forms should include mention of most of the common tests done for the hospital, and they are often printed in duplicate, so that the laboratory can retain a copy of the result of the examination for future reference. A sample form is reproduced below.

The duplicate of this card is filed in the laboratory, the original being returned to the hospital ward. It will be noted that a space for a

LAB. NO.		LABORATORY RECORD			PLEASE FILL OUT ALL SPACES EXCEPT "PATHOLOGICAL REPORT" OTHERWISE IT MAY BE IMPOSSIBLE TO PERFORM TEST ALSO USE SEPARATE CARD FOR EACH REQUEST.	
NAME						DATE
REQUEST OF DR.		(INTERN): DEPARTMENT			WARD	
N. B. PLACE MARK OPPOSITE PROPER TERM IN EACH COLUMN, AND UNDERLINE EACH TEST WANTED, IF MORE THAN ONE IS GIVEN.						
FOR DIVISION OF:		SPECIMEN OF:		EXAMINATION REQUESTED		Cross Out Bracket, If Not Desired
CLINICAL PATHOLOGY	SMEAR (STATE KIND)	PREVAILING ORGANISM				
	SPUTUM	T. B.: DIPTH. BAC.: G. C.				
	FECES	OVA & PARASITES; OCCULT BLOOD				
BACTERIOLOGY	BLOOD	HB. (RBC. <u>if HB.</u> under 12) LCTS. (DIFF between 7&10,000)				
	SPINAL FLUID	WASSERMANN				
	EFFUSION (STATE KIND)	COLL. GOLD; CELL COUNT; GLOB.				
BIO CHEMISTRY	URINE	CULTURE				
	MISC.	MISC.				
	SEROLOGY					
DIRECT SMEARS						
CHOLEST. ANT.						TUB. BAC.
NOGUCHI ANT.						G. C.
G. C. COMP. FIXATION						MISC. BACT.
COLLOIDAL GOLD						
WIDAL AGGL. T. A. B.						PUS CELLS MANY FEW ABSENT
CLINICAL NOTES: [IF WASSERMANN, GIVE DETAILS OF TREATMENT]						
CLINICAL DIAGNOSIS: [IN CASE OF DOUBT, ADD "?" TO PROVISIONAL DIAG.]						EXAMINED BY

Sample of laboratory request form.

BODY FLUIDS	BLOOD COUNTS	GASTRIC CONTENTS	BLOOD CHEMISTRY
COLOR	HEMOGLOBIN	GRAMS	UREA N. MG
APPEARANCE	R. B. C.		CREATININ
SP. GR.	W. B. C.		URIC ACID
CELLS PER CU. MM.	POLYS %		SUGAR
SUGAR	LYMPHO. %		CHLORIDES
PROTEINS	MONO. & TRANS. %		CHOLESTEROL
GLOBULIN	EOSINO. %		CO ₂ C.C.
POLYS %	NEUTRO. %		
LYMPHO. %	SPECIAL		
ENDOTH. %			
R. B. C.			
SMEAR			
RESULTS OF CULTURES			
PUS. FECES. URINE. SPUTUM. BLOOD. SHOWS:			
SPECIAL CULTURES			
THROAT FOR DIPHTHERIA			
NOSE FOR DIPHTHERIA			
MISCELLANEOUS			

Reverse side of form shown above.

time stamp imprint has been provided, in order to fix the responsibility definitely in case of delay in the receipt of this report in the ward. Too often the reply which a visiting chief receives from his intern, when an inquiry is made as to the result of a Wassermann test, for example, is, "The report has not returned from the laboratory," the onus for the delay being, therefore, placed upon this division. In the institution employing the type of request shown here, a separate sheet has been adopted for urinalyses reports, in order to save printing costs. It is usually not felt necessary to make out these reports in duplicate to enable the laboratory to keep an accurate file of results of the examination of urine.

The laboratory must of necessity have many other forms in use. Reference is here made to requisitions for chemical examinations, basal metabolism studies, tissue diagnoses (post-mortem), etc. In regard to the latter form of request, it is customary to place on the report sheet, in separate columns, the gross anatomical diagnosis and the histologic diagnosis. A request form for this type of work, as well as one for the examination of tissue from the operative suite, is usually made on sheets, 8½"x11", in order that these papers may be conveniently filed with the patient's chart.

A request sheet for the latter type of tissue diagnosis should contain besides the name, age and department of the patient, a space for clinical notes and clinical diagnosis, as well as ample space for gross and microscopic description and for pathological diagnosis. It has been found wise to send a copy of this sheet, as well as a copy of the sheet containing the result of the postmortem examination, to the visiting chief under whose care the patient is or was. This serves to stimulate greater interest on the part of the clinician.

Speeding Up the Laboratory Service

Any break in the chain of events, which begins with the collection of specimens and ends with the copying of the results on the chart, will nullify the good work that may have been done anywhere along the line. Inaccurate measurements of fluid output or intake on the part of the nurse, improper preservation of urine specimens, with resulting fermentation of urine, will destroy the value of careful laboratory studies. The mixing of specimens, from the standpoint of the patient's name; a delay in the collection and transportation of specimens to the laboratory; improper incubation of smears or cultures, particularly those collected at night, are but a few of the mistakes that react to the disadvantage of the patient.

Some hospitals maintain a regular, well worked out messenger service, which provides for the collection of specimens from all hospital departments several times a day. This system even though it requires an additional member of the hospital personnel is perhaps the most satisfactory, because it is under the direct control of the laboratory.

In other institutions the hospital departments are responsible for the delivery of specimens to the laboratory, and any carelessness on the part of orderlies, which results in the destruction of specimens that have been collected, or which eventuates in delay in transportation, nullifies the complete effectiveness of the laboratory, even although its equipment and personnel are of the best.

"Stat" requests for blood counts, blood chemistry or for any other emergent study, should be immediately phoned to the laboratory if collection of the specimens is to be made by that department. Even although the specimen is to be sent by the hospital department, a phone call explaining to the laboratory worker the urgency of the case is usually worth while.

The Postmortem Room

The establishment by visiting chiefs of a minimum standard of laboratory studies to be carried out on the admission of certain types of patients oftentimes speeds up the study of the patient's condition. If the intern must delay until his chief visits the hospital before instituting any laboratory work, at least a day is lost in starting treatment.

Most institutions perform Wassermann tests twice or thrice weekly, and an effort on the part of the resident physician to secure blood and spinal fluid specimens on the day previous to Wassermann day oftentimes will save time for the patient and the hospital.

The laboratory day should not close until all work waiting has been performed. This latter statement refers, of course, to current requisitions and not to research or other studies, delay in which in no way effects the progress of the patient's treatment.

On the other hand, routine laboratory work can be expensive to the hospital and to the patient, if too widely adopted. This usually does not consist of more than a urinalysis, a blood count, and in certain departments a Wassermann test or blood urea and blood sugar studies. Most psychopathic institutions require routine Wassermann tests on all admissions.

Detailed comment has been made in an earlier issue (September, 1926) of THE MODERN HOSPITAL, relative to the need for a commodious, well

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lighted and airy room for the performance of post-mortem investigations.

It is the duty of the director of the laboratory, or, if no such officer is attached to the hospital, of the superintendent, to see that the highest morale, from the standpoint of scientific procedure and personal conduct of personnel, is always to be found here.

The intern must be given an opportunity to learn the technique of skillfully performing post-mortem examinations, not as an observer but by actually doing this work himself.

The supervision of incisions used in this operation is also a matter of the greatest moment to the hospital, for carelessness or lack of thought in this matter is likely to bring avoidable reproach on the hospital. Any departure from the routine midline incision, extending from the suprasternal notch to the symphysis pubis, should be approved by one of the officers mentioned above.

The feeing of laboratory attachés by undertakers, in consideration of aid given them in placing bodies in their conveyances, is pernicious in its tendencies and should be prohibited.

When the practice of making an additional charge in the case of bodies that have been subjected to postmortem examination, comes to the attention of the superintendent, a businesslike conference with the offending undertaker often brings results.

CORRESPONDENCE AND REQUISITIONS

Many hospital executives insist rigidly on the routing of correspondence through certain channels. If a fireman wishes to address the board of trustees concerning an increase in salary or a fancied or a real grievance, this letter goes by way of the chief engineer and the superintendent. On the other hand, if a member of the board wishes to officially interview the chef, he usually does so in the presence of the dietitian and the superintendent. Most boards of trustees insist on this official routing of requests, complaints and commendations within their hospital, because they feel that by so doing the elements of jealousy or suspicion are much less likely to enter into the transaction of hospital business, especially between the various departments.

Requisitions usually go by the same route. A requisition for a dozen brooms, originating in the office of the housekeeper of the nurses' home, comes to the superintendent's desk by way of the superintendent of nurses' office, and is thence dispatched to the storekeeper. To adhere to the rule is not always possible, but, by and large, it is a wise procedure.

DANGER OF INTRAVENOUS INJECTIONS

The danger of the intravenous administration of a solution of sodium chlorid, which is almost equally harmful to the patient whether in more concentrated or less concentrated form, than the blood stream, should be strongly impressed upon the minds of nurses, interns and others in the hospital personnel.

SURVEY OF OPERATING SUITE

It is good institutional practice for a monthly or bimonthly survey of the operative suite to be made by the hospital bacteriologist. Culturing of gauze preparations, instruments, gloves, the hands of surgeons and nurses, dust from window-sills, solutions, and other articles in the operating room, usually comprises this study. In this manner post-operative infections can be more certainly traced to their source.

COLOR SCHEME IS PLANNED WITH CARE

In the new Medical School and Hospital of the University of Colorado, Denver, the color problem for walls and furnishings has been worked out in detail, according to the *Atlantic Medical Journal*. The x-ray room has walls of a violet red, which has great light absorption power yet exerts a quieting influence on the patient and is slightly stimulating to the operator. In the operating theater a soft gray is used. The wards for disturbed patients have yellowish green walls, because this color has been found to have a tranquilizing and cheerful influence. Rooms with a northern exposure have yellow walls, and those with a southern outlook, with sunshine, gray walls and furnishings.

PROTECTING CORRIDOR WALLS FROM MARRING

The problem of preventing corridor walls from being chipped by the impact of stretcher and food carts, which so often results in unsightly marks, has been successfully solved through the use of linoleum by a hospital in the East. The building which is old, had no protecting cove base and the walls were chipped daily.

The superintendent after trying several remedies resolved to try linoleum. An inferior grade, thirty-six inches wide, was obtained and glued to the wall with liquid cement, the lower edge being placed directly above the baseboard. This solved the problem. The walls are protected, the walls and the corridors present a more pleasing appearance and are easier to keep clean.

LIMITING INTERVIEWS

Some hospitals have a rule limiting the interviews with salesmen to twice a week. A new hospital in Missouri started out with this plan but soon modified it to take care of exceptional cases. It limits calls from local salesmen to twice a week; Tuesday and Friday mornings from 9 to 12, but all out-of-town salesmen are admitted whenever they call.



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HIGH EDUCATIONAL STANDARDS MUST BE UPHELD

THE current medical press offers a variety of opinions on the question of the extent and type of education that the student nurse should receive. There is much bewailing of the passing of the old-fashioned nurse—the type of woman who, being eminently practical in all her dealings with the sick, possessed the added virtue of being willing to labor twenty-four hours without rest or food, if need be. Just as much insistence is noted in other periodicals for restricted hours of work and for higher educational standards for the student nurse. Among the members of the medical profession there appears to be a decided feeling that their sister calling is not solving this problem with the speed that seems demanded. The nurse, with perhaps somewhat justifiable firmness, insists that the problem is one that vitally concerns the doctor and that he must aid in settling.

At the outset, THE MODERN HOSPITAL desires its position on this question to be plainly understood. This magazine stands for high educational standards for the nurse, and has advocated and will continue to urge any step that in its opinion promises better care for the sick. It does not believe that the answer to this question lies either in lowering admission requirements or in shortening courses of study.

We have no doubt that the coordinated efforts of the great medical, nursing and welfare bodies which are devoting their best thought toward solving this problem, will result in its satisfactory solution.

If, however, the aim of all nursing education is to equip young women better to serve their fellow men, it would appear that no increase in standards or shortening of hours is excusable, unless it is consonant with the rendering of adequate service to the patient in the hospital.

To insist on an eight-hour day for the student nurse is no doubt a wise step insofar as her physical condition is concerned, but to demand this length of service in a hospital where baths and medication must wait while the nurse recreates on the tennis court seems hardly justified. We do not believe that the leaders in this profession advocate or would sanction any step that works a hardship on any patient. We do not think that the ugly term of "trade unionism," in reference to the fees and hours of the nurse, is applicable in regard to the calling of Nightingale, Sister Helen or Robb. We believe that there remains in the ranks of the nursing profession much of the altruism and many of the fine traditions that have characterized it in the past.

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But whatever advances are made in the business of caring for the sick, whether from a nursing angle or from the laboratory or experimental study of the patient, must be brought about not with the betterment of the nurses' health and wealth or even the theoretical betterment of future patients wholly in view, but with the adequate care of the present day patient as well clearly in mind.

The education of physicians and nurses and the solution of medical riddles through research are important, but the prevention and cure of disease are and must continue to be the prime reason for the hospital's existence.

MORE PHYSICIANS NEEDED FOR RURAL COMMUNITIES

A NUMBER of studies of the distribution of physicians and of health services in different sections of the country have been made in the last few years. There seems to be a general agreement, as shown by these studies, that the health services in the small and rural communities are considerably less satisfactory than they are in the cities; that the average age of physicians practicing in these communities is rapidly rising and that it is only a question of a few years until many of them will no longer be active and many will have died, and that recent graduates in medicine are not locating in the smaller communities in sufficient numbers to meet the needs of these communities.

Most of the studies come to the conclusion that the fundamental causes are economic and social, and are a part of the large agricultural question that is engaging the attention of the national legislature and numerous national bodies. It is important for the medical and hospital professions, however, to ascertain if there are any aspects of this general situation that they might alleviate. Indeed, there is a great responsibility upon the professional health groups to devise methods of meeting this situation and the public has a right to expect leadership and plans to be developed by them.

A number of different suggestions have been made to meet this situation, many of them taking the form of direct or indirect subsidies, bonuses, guarantees or other financial inducements to practitioners to locate in given communities. Most of these schemes, however, have not attracted the most competent physicians, nor have these plans received endorsement by the organized medical profession.

The fact that there has been a marked change in methods of medical practice in the last few

years must be thoroughly weighed, in any consideration of this problem, particularly as this change in medical practice has been reflected in the teaching centers where splendid hospitals, laboratory, x-ray, clinic and other facilities have been developed and where also a body of additional personnel, such as social workers, nurses, administrators, physiotherapists, laboratory technicians and others, are employed to supplement medical practice through hospital, visiting nurse and clinic organizations.

It is in this atmosphere that the medical students of the present day are trained and receive their hospital experiences before going into practice. It is becoming generally agreed that a number of these facilities are necessary to give an adequate health service to the community, and it is only natural that the recent graduate of medicine prefers to remain where he feels that he may practice as he has been taught.

It is true that some of the best informed medical educators feel that the pendulum has swung too far, and attempts are being made to correct some of the defects of current medical instruction which tend to a certain extent to disqualify men from doing individual general practice. However, the fact remains that many of these facilities are necessary for a comprehensive service. Even for persons of limited or moderate means, clinic and hospital facilities have been developed to an extent where in some cities 25 per cent of the sick population of the community receive all or part of their medical attention in clinics, either free or on the basis of a nominal charge, and 75 per cent of the hospitalized illness is provided without additional charges for medical services.

If these hospital, clinic, laboratory and nursing facilities are necessary for the adequate practice of medicine in the cities, it is only logical to expect that they are necessary in the smaller community, and where they have been developed there has been no difficulty in securing trained health workers and a sufficient number of well trained physicians.

The development of a plan of comprehensive medical service is not the responsibility of physicians alone. In the cities the costs of construction and maintenance of the hospital and of clinic and laboratory programs have been met by the community at large and not by individual physicians. This points to the importance of cooperative effort between the medical profession and the public and calls for a type of leadership on the part of medical practitioners that will direct these programs along sound professional and community lines, an emphasis that has yet to appear to any extent in medical training.

Any community that has developed a sound, broad, hospital program, organized and maintained in relation to the needs of the given community, will have no difficulty in securing trained medical and other personnel and in meeting 95 per cent of the health needs of the community. The development of a sound program of community hospital centers promises to be the largest single factor in the distribution of well trained physicians and in insuring adequate health service for the community, particularly for the large group of persons of limited means in the smaller communities and their tributary rural districts, who at present are threatened with lack of, or are already deprived of, adequate medical attention.

THAT EIGHTY PER CENT

PERHAPS no individual statement was more startling to the majority of the delegates at the recent meeting of the American Hospital Association than the pronouncement that the middle class—those who are neither rich nor poor—comprises four-fifths of the country's population. In other words, when eighty out of every one hundred persons in the United States become ill, they are more or less embarrassed in providing for themselves so-called private room service, with the added expense for physicians' and nurses' fees.

Even though our hospitals are adequately serving the remaining one-fifth, which includes the rich and the very poor, it would seem that it is high time to turn attention to the needs of this great group of persons of moderate means, who it appears have been somewhat neglected hitherto.

As was pointed out editorially in our November issue the solution seems to lie in increasing and perfecting semi-private (perhaps semi-public would be a better term) facilities. Indeed, hospitals in several localities of this country have already realized the existence of this need, and have erected especially designed buildings.

The more general adoption of group nursing, or some similar plan, which will bring this service within the economic reach of these patients, is as important to their successful care as is the construction of buildings in which properly cubicled four-bed and six-bed wards predominate.

The fact that a false pride often forces the sick man or woman to the expedient of borrowing against life insurance policies or the mortgaging of the home in order to meet private room costs, should not signify to the superintendent, uninformed as to the source of funds so apparently easily forthcoming, that the problem does not exist in his community.

Nor should it be forgotten that, while this coun-

try is unquestionably enjoying an unprecedented wave of national prosperity, the cost of living is still far from the pre-war level. Moreover, the salaries of teachers, clergymen and clerks have not been advanced, either in proportion to the present day financial requirements of their place in society, or, in some instances, even to the needs for mere respectable existence.

To provide a hospital service which is neither offensive to the self-respect, nor exacts a financial outlay disproportionate to the moderate means of this group of our population, is a problem that is worthy of careful study by the hospital world.

TALKING IT OVER

DO you remember what Sir William Osler said about vaccination?

"I will go into the next severe epidemic of small-pox with ten selected vaccinated persons and ten unvaccinated persons. I should like to choose the latter—three members of parliament, three antivaccination doctors, if they could be found, and four antivaccination propagandists. And I will make the promise neither to jeer nor to jibe when they catch the disease but to look after them as brothers, and for the four or five who are certain to die, I will try to arrange the funerals with all the pomp and ceremony of an antivaccination demonstration."

Satirical? Yes, but thought provoking, certainly.

* * *

THREE is a disease that occurs sporadically among young hospital interns and nurses. It is not known whether it is contagious or infectious. It temporarily destroys the efficiency of the keenest physician or the most capable nurse. It produces loss of memory and a general state of confusion and indirection in performing the day's work. There is no preventive treatment known, and curative effort is not at all satisfactory. The wisest and most experienced hospital and training school executives often stand aghast at the virulence and destructiveness of this institutional pestilence. The disease is variously denominated as *liebeskrankheit*, *mal d'amour* or, in everyday English, lovesickness.

* * *

HIP pockets for pupil nurses! Well, one directress of nurses has had to legislate against this new form of attack on male supremacy, because vanity cases just could not be kept off the wards. At any rate, there is no danger of these apparently necessary articles being concealed in coiffures!

* * *

“HOW much does it cost a day to run a 100-bed hospital?" is about as sensible an inquiry as to request information as to the expense of conducting a factory, one thousand feet long. To use per capita cost as indicative of the economical expenditure of the community's money is almost as fallacious, unless such facts as the type and quantity of work performed, the speed of bed turnover, the method of computing daily patient cost and the one and a dozen other factors, equally important, are taken into consideration. Often it becomes a question of who tells the story first, when the battle of per capita cost comparison wages hottest among hospital workers. Until standardization of methods of per capita cost computation prevail another yardstick must be used.

THE statement was made recently that the work of a certain organization constantly improved because of a "noble dissatisfaction." We like the expression and think of it in terms of its application to the progressive hospital executive. His is not the petty dissatisfaction that tolerates mediocrity of accomplishment or manifests itself as an inferiority complex, but the same healthy dissatisfaction which repulses the idea that the way we did things last year was the best way possible. Let us all encourage the spirit of "noble dissatisfaction" in our hospitals and in ourselves.

* * *

IF THE war taught us anything—and this is debatable—it is that it takes more than a few song leaders to create morale. The lad who could stutter through "Beautiful Katie" played his part, but when the mud was deep and the cootie had an open season for doughboys, it was the leather-lunged top sergeant with the disposition of a hungry bobcat, and the drawing room deportment of a rhinoceros, who stiffened the laggards and made men fight. It's a long way from trenches and duckboards to the peace time hospital but the principle is the same. Morale isn't upbuilt by singing about work but by doing it, by living it, by eternally keeping at it. The cheer leader is a noble institution but it's the team that scores the victories.

* * *

TO THE sick, food should be something more than physical nourishment, something that is beyond a mere melange of carbohydrates, proteins and fats. It should transcend calories, vitamins and roughage, and become to the body what a poem is to the ear, satisfying but not satiating, stimulating rather than stupefying, a fillip to the imagination, a gentle surprise but not a rude shock. Plain wholesome food may be sustenance, it may stoke the vital furnaces to the end that a given number of ergs may be produced, but in dealing with tissues that are to be brought back to a normal state there must be an admixture of the vitamin of art. Its plainness must be the simplicity of real beauty in order that it may appeal to senses jaded by disease, and it must be as nourishing to the spirit as to the body.

* * *

LIFE had not dealt gently with him, yet from his weather furrowed face his watery blue eyes shone with love and sublime faith. The broken nailed fingers of his calloused, work-cracked hands displayed a velvet covered jeweler's box in which reposed a platinoid ring, all brave with imitation diamonds and sapphires—tawdry and cheap, yet a sacrifice. "Tis better 'twill be making of herself!" and proudly he bore his offering into the ward where his daughter, the mother of a nameless child, was making a bad, slow business of giving up a life in which hope and desire of existence were already dead.

* * *

HOSPITAL people who are readers of the *Atlantic Monthly* must derive much pleasure from the articles of Dr. Mary Griscom, relative to customs in the institutions of India, Persia and China. The pleasant custom of inviting professional visitors to luncheon when they happen to be in the hospital at noonday, exists, it seems, in other countries than ours. To observe long rows of diners—doctors, nurses, and attendants—sitting cross-legged on the veranda of an American hospital, eating the equivalent in this country (if there be any) of chutney and pilau, with their fingers, would cause a sensation, at least, in some communities. Even the most vain hospital superintendent, in consideration of the entertainment gained in

reading Dr. Griscom's article in the October issue, can forgive her satirical remark that, "It is strange how some men still feel that woman is a rib, useful in keeping man inflated."

* * *

THE following item contributed by a patient to a tuberculosis sanatorium magazine seems to be an argument for resilient floors:

Crash! and another milk bottle proves that it cannot stand to be dropped upon the adamantine floor. "Who is that applauding out in the hall?" "Nobody applauding; just someone with an over-size pair of slippers walking by." "Naw, there ain't nobody scrappin out there. It's only 'Charlie' mopping the floor."

* * *

CHEERFULNESS, the smiling countenance, the glad hand have at various times been extolled as virtues to be exemplified by the hospital field. Conversely, the sober countenance, the gloomy grouch and the "icy mitt" have been held up as horrible examples of what to avoid. But, after all, isn't there a middle ground between the two? The professionally cheerful person is to most patients about as heart-lifting as a choir leader with adenoids. There is something convincingly genuine about a thoroughgoing grouch but the smirk which is assumed for the occasion fools nobody and breeds lack of confidence. Patients want somebody whom they can trust and ill-timed, artificial cheeriness is a self-apparent sham which irritates and depresses them. They appreciate far more the person who is honestly natural without a hint of specious jollity.

* * *

MANY beginners in the hospital field are wondering just what is the formula by which they shall achieve success. There is no magic abracadabra to that much desired end. Success cannot be "Couéd." Idle dreams go unrewarded. One must purpose; then do; and continue doing. A glacier is not turned aside by little things; drift ice swerves at the smallest obstacle. If your purpose is really great, it will drive relentlessly to the desired goal; if it is not, it will be diverted by every impediment. The secret of success is willing, doing, continuing.

* * *

THE fact that many research workers die of the disease to the study of which they devote their lives is recalled by the centenary of Laënnec, which was celebrated on August 13, 1926, in Brittany, France. The father of auscultation, who by his studies of diseases of the chest, added enormously to our knowledge of tuberculosis, himself died of the disease on August 13, 1826. Born at Quimper, France, on February 17, 1781, he returned from Paris where he had gained international and undying fame to die at the manor of Kerlouarne, at Ploaré near Douarnenez, not far from Quimper. The celebration of the centenary of his death included a service in the parish church of Quimper, homage at Laënnec's tomb, where addresses in French and Breton were made, a visit to Kerlouarne, and a banquet.

* * *

THERE is no arena of human endeavor that more continuously demands decisions than does the hospital field. Situations arise daily which require the exercise of judgment and human welfare and happiness depend upon the decisions made. Many of these are puzzling in the extreme and demand the greatest force of character. It is a great temptation to straddle the fence but respect for self and the job prohibits this. In fact it cannot be done successfully.

NEWS OF THE MONTH

SOUTHERN ASSOCIATION FORMED AT ALABAMA MEETING

Plans for the formation of the Southern Hospital Association as a section of the American Hospital Association were one of the interesting features of the annual meeting of the Alabama Hospital Association held recently at Mobile. About seventy-five attended the convention. The sessions were held under the chairmanship of Dr. Francis Goodwin Du Bois, president, who is superintendent of Vaughan Memorial Hospital, Selma, and who sponsored the organization of the new association.

Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans, La., was elected president of the new association. The other officers are: Dr. S. H. Hairston, Meridian, Miss., vice-president, and Dr. J. Q. Folmar, State Psychopathic Hospital, Chattahoochee, Fla., secretary-treasurer.

The conference consisted of several addresses on important hospital problems, round tables and business sessions.

Dr. John D. Spelman addressed the assembly on the subject, "The Ideals that Motivate the Twentieth Century Hospital," and made a strong plea for the hospital to treat the man as well as the disease.

Dr. Folmer discussed the medical problem of state psychopathic hospitals, urging cooperation between this branch of service and the general hospital.

In his presidential address, Dr. Du Bois contended that hospitals as well as individual physicians should be made to pass tests before being granted a license, and he quoted statistics to show that out of the group of hospitals of from 35 to 50 beds in this country only 18.3 per cent could pass inspection.

Mary D. Roberts, editor, *American Journal of Nursing*, New York, delivered an address on "The Trend of Nursing" in which she pointed out the grave situation that has arisen as the result of the shortage of trained nurses. In the South, she said that only thirty student nurses out of every 100,000 population have registered in schools of nursing.

Papers were also read by Annie Beddow, R.N., president, State Nurses' Association; Jesse Mariner, R.N., director, Child Hygiene Association of Alabama; Miss McFadden, R.N., T. C. I. Hospital, and Minnie Kruger, R.N., Inge-Bondurant Sanitarium, Mobile.

The conference concluded with a banquet at the Cawthon Hotel.

DR. L. B. BALDWIN DIES

Dr. L. B. Baldwin, superintendent of the University of Minnesota Hospital, Minneapolis, since 1910, died October 24, at the age of fifty-four years.

Dr. Baldwin has been in hospital administration work for many years and has been active in both national and local hospital and medical work in which he gained a wide reputation as an organizer and administrator. He organized the Hospital for Feeble-minded at Grafton, N. D., and spent four years as superintendent of the

North Dakota State Hospital for the Insane, Jamestown. Following his work there he went to the University of Minnesota Hospital where he remained until his death, with the exception of the period during the war in which he was attached to the offices of the Surgeon-General of the United States.

He entered the Army in 1918 as major and in 1919 was commissioned colonel in the medical reserve corps, and was then placed in charge of personnel and administrative affairs in the medical corps.

Dr. Baldwin also took an active part in medical work,



The late Dr. L. B. Baldwin.

having been medical director of Nicollet Clinic, Minneapolis, from 1921 to 1924. He was active in the affairs of the American Medical Association and was president of the American Hospital Association in 1921.

He was born in 1872 and was graduated from the University of Minnesota Medical School in 1897. He is survived by his wife, daughter, mother and two brothers.

The House of Representatives of Louisiana has passed a House Abuse Bill requiring all applicants (excepting emergency cases) for care in a charity hospital to fill out official blanks which will give evidence as to the patients' financial standing.

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THE MODERN HOSPITAL TO START READING COURSE ON ADMINISTRATION IN JANUARY

A READING course for hospital executives will be started with the January issue of *THE MODERN HOSPITAL*. This course will appear in consecutive issues throughout a period of two years. The proposal for such a course has been under consideration for a number of years and the action taken at this time is in response to an increasing number of requests from the field for such a service. The purpose of this course is to present the fundamentals of hospital administration and to further the education of superintendents, assistant superintendents and other executive personnel of hospitals who are anxious either to "brush up" on administration problems or who wish to learn the underlying principles of successful hospital administration.

Course Sponsored by Leaders

The course will be under the direction of C. W. Munger, M.D., director, Grasslands Hospital, Valhalla, N. Y., E. H. Lewinski-Corwin, Ph.D., who is conducting a similar course on "Economic and Sociological Aspects of the Hospital," at New York University, New York, and Edgar C. Hayhow, superintendent, New Rochelle Hospital, New Rochelle, N. Y., who is conducting a course in institutional management at New York University. In addition to these three men, the course will have an advisory board of four hospital administrators, namely, Joseph C. Doane, M.D., director, Philadelphia General Hospital, Philadelphia; A. C. Bachmeyer, M.D., director, Cincinnati General Hospital, Cincinnati; Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago; and Frank E. Chapman, director, Mount Sinai Hospital, Cleveland.

The courses at New York University have met with considerable success during the past two years and at the present time there is a large class that meets once a week. *THE MODERN HOSPITAL* has been interested in training facilities for hospital executives and has given its support to every forward movement of this nature that has been projected, and, while undoubtedly hospital executives would receive a more complete course by the attendance at schools such as those that are already established at Marquette University, Milwaukee, Wis., under the direction of Edward A. Fitzpatrick; at Temple University, Philadelphia, under the direction of Charles S. Pitcher, at New York University, and at other schools throughout the country, it is not always feasible for prospective students to leave their work for attendance at such places. Therefore, inasmuch as these people cannot go to school it was decided to bring the school to them in the form of a reading course. By combining the instructions of Dr. Corwin and Mr. Hayhow under the supervision of Dr. Munger, with the consulting board of Dr. Doane, Dr. Bachmeyer, Mr. Bacon and Mr. Chapman, students will be in a position to obtain the best instruction available without leaving their respective institutions.

New York University recently said of its institutional management course:

"Institutional management was for a long time regarded as something that must be learned by actual experience. During the past few years, however, partly as a result of the increased size in modern institutions and also partly because of a more intensive study of the problems in this field, there have been developed principles and practices that are today generally adopted."

"The purpose of this course in institutional management is to be of service to those who are employed in institutions as well as those who are planning to enter the field by making them familiar with the fundamental principles of institutional organization.

"Such topics will be discussed as institutional planning, campaigns, organization procedures, relationship between the board of directors and the superintendent, the personnel, office methods and procedures, application of cost accounting and general systems to institutions.

Following this statement is the general syllabus in which are listed organization and management, fund raising, institutional planning, selection of personnel, office methods and procedures, statistics, insurance, purchase and storage of foods and supplies, handling of foods, equipping the kitchen, housekeeping, laundry work, humanizing the institution, group inspection, conferences, and other topics.

In speaking of the course in hospital economics the prospectus says:

"The aim of this course is to present a picture of hospital and institutional needs from the viewpoint of the community.

"A comprehensive study will be made of the various types of hospitals and the service rendered by them together with the convalescent and chronic conditions warranting institutional care. The various interrelationships of medical and social programs and the organization of medical, nursing and out-patient work will be discussed.

"Vital statistics, economic and sociological factors of disease, modern health programs, public health and institutional medicine will be taken into consideration throughout the year. The fundamental principles underlying the solution of research problems will be discussed, with special emphasis on research opportunities that are available in hospitals."

THE MODERN HOSPITAL, in addition to publishing these lessons of the reading course will, from time to time, recommend additional reading, and while this will not be a correspondence course in the strict meaning of the term, those who will follow this course will feel free to ask any questions that may arise.

TWO CITIES CONTEND FOR A. H. A. MEETING PLACE

The 1927 convention of the American Hospital Association will be held either in Minneapolis, Minn., or Kansas City, Mo., according to the decision reached at the board of trustees' meeting held in Chicago, November 15 and 16. It was further tentatively decided that the association would meet on the Pacific Coast in 1928, if a suitable meeting place can be arranged for at that time.

Dr. E. T. Olsen, superintendent, Englewood Hospital, Chicago, chairman of the legislative committee, was authorized by the trustees to go to Washington, D. C., for a conference with Senator Royal S. Copeland (New York) regarding the thermometer bill that has been introduced by him. This bill will be up for consideration on December 5 and it is the hope of the association that it will be blocked, as it is the association's belief that such a bill as is now pending would increase the cost of thermometers without materially improving the product.

Most of the session of the trustees was spent in discussing budgets and intramural work.

A. C. OF S. CONFERENCE FEATURES NURSING PROBLEMS AND PRACTICAL DEMONSTRATIONS

MANY benefits resulted from the Hospital Standardization Conference of the American College of Surgeons held at the Windsor Hotel, Montreal, on October 25, 26, 27 and 28, with an attendance better than has heretofore been accomplished at similar meetings. Surgeons, hospital superintendents and nurses from all parts of the United States and Canada were present, as well as foreign visitors from Australia, New Zealand, England and other European and South American countries. A dinner in honor of the foreign distinguished visitors was held on Monday evening.

The opening session on Monday was taken up by addresses of an official nature, reports and papers. Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, delivered the opening address and following him, General Sir Arthur Currie, principal, McGill University, Montreal, spoke. Dr. Rudolph Matas, New Orleans, La., retiring president of the American College of Surgeons, spoke upon the hospital standardization movement, and the presentation of the official report of hospital standardization for the year 1926 was made by Dr. Franklin H. Martin, director general of the college.

An interesting paper was presented by Prof. David P. D. Wilkie, Edinburgh, Scotland, who told of the British hospital problem and how it is being solved in the British Isles.

Impressions of a New Zealander on hospital standardization were outlined by Dr. L. E. Barnett, professor emeritus of surgery, Otago University Medical School, Dunedin, N. Z. He was followed by Dr. D. Sclater Lewis, Montreal, representing the American College of Physicians, who spoke on the minimum standard as applied to the department of internal medicine. The closing address of the morning was given by Dean Edward A. Fitzpatrick, Graduate School, Marquette University, Milwaukee, who spoke on the graduate school and the work that it was doing at Marquette University.

The afternoon session was given over to the nursing problems of hospitals and the symposium was opened by Dr. Haywood who eulogized the nursing profession and stressed the splendid service that the nurses are rendering.

Nursing Work in Montreal

Dr. W. W. Chipman, professor of gynecology and obstetrics, McGill University, and newly elected president of the American College of Surgeons, was the first speaker and he told of the work that is being done by the nursing profession in Montreal. He said that while the pay was in most cases only adequate the spiritual compensations were great. He pointed out, however, that something should be done toward the establishment of a fund for old age and retirement pensions for nurses.

Dr. A. T. Bazin, Montreal, then spoke upon the qualifications that the medical profession expects from the nurses. He spoke of the careful selection of students, proper training, loyalty and cooperation. Dr. John E. Jennings, Brooklyn, followed Dr. Bazin and took as his topic for discussion, "Present Status of Nursing From the Standpoint of the Medical Profession."

Dr. J. L. Austin, professor of clinical surgery, Queen's University, Kingston, Ontario, stated that he believed that adequate pay for nurses will eventually come through some form of insurance.

The present status of nursing from the viewpoint of the hospital superintendent was outlined by Dr. John E. Dougherty, superintendent, Jewish Hospital, Brooklyn, N. Y. He stated that he believed more training of nurses for bedside work and ward routine was necessary to relieve this situation, as registered nurses for this work are disappearing and assuming more lucrative positions outside the nursing profession. He recommended that the College of Surgeons appoint a sub-committee to consider the matter of training bedside nurses. Dr. Dougherty's paper was discussed by Col. Louis C. Trimble, superintendent, New York Post-Graduate Medical School and Hospital, New York. He stated that frequently hospitals receive nurses who are totally lacking in fundamental training and are extremely difficult to fit into the general scheme of hospital organization.

Laura R. Logan, R. N., dean, Illinois Training School for Nurses, Chicago, was the next speaker. She stated that the simplest and best method of giving the public what they want in nursing is to adopt a minimum standard similar to the minimum standard that has been adopted for hospitals.

Nursing Leaders Present

Frances L. Reed, R. N., instructress of nursing, Montreal General Hospital, Ethel M. Sharp, director of instruction, Royal Victoria Hospital, Montreal, Alice S. Gilman, R. N., secretary, State Board of Nurse Examiners, University of the State of New York, Albany, N. Y., Flora M. Shaw, R. N., president, Canadian Nurses' Association, Montreal, Janet M. Geister, R. N., assistant executive secretary, Associated Out-Patient Clinics of New York, New York, Carrie M. Hall, R. N., president, National League of Nursing Education, Boston, and Dr. May Ayres Burgess, Committee on the Grading of Nursing Schools, New York, were all present and contributed to the discussion.

At the dinner and meeting that followed the following distinguished foreign guests were present: Prof. David P. D. Wilkie, Edinburgh, Scotland; Prof. Roberto Alessandri, Rome, Italy; Sir Ewen Maclean, Cardiff, Wales; Prof. Archibald Young, Glasgow, Scotland; Prof. John M. G. Fraser, Edinburgh, Scotland; Prof. W. Sampson-Handley, London, England; Dr. Louis E. Barnett, Dunedin, New Zealand; Prof. Ricardo Palma, Lima, Peru; Rudedende da la Fuente, Valparaiso, Chile; and Prof. Luiz de Rezenie Puech, Sao Paulo, Brazil.

Many speakers crowded the program of Tuesday morning's session. Dr. A. L. Gilday, superintendent, Western division of the Montreal General Hospital, presided and introduced the first speaker, Rev. C. B. Moulinier, president, Catholic Hospital Association, Milwaukee. Father Moulinier spoke upon what seemed to be needed in most hospitals and outlined some of the outstanding faults of present-day administration. He was followed by Rev. Newton E. Davis, corresponding secretary, Board of Hospitals, Homes and Deaconess' Work of the Methodist Episcopal Church, Chicago. He added to the remarks of Father Moulinier and spoke of the work that was being done in his group to correct faults.

The next three speakers told of work in the operating room and the methods that were being introduced to make the work surer, better and technically more accurate.

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The speakers were Dr. Southgate Leigh, Norfolk, Va., Dr. W. Frank Fowler, Rochester, N. Y., Dr. George Gray Ward, New York. Dr. F. H. Slayton, Mellon Institute of Industrial Research, Pittsburgh, told of the work that was being done toward research and standardization of the hospital supplies that were being investigated by the institute.

John A. McNamara, managing editor, **THE MODERN HOSPITAL**, spoke on open and closed hospitals. He quoted many authorities on the subject, notably Dr. S. S. Goldwater, Dr. A. C. Bachmeyer, Dr. M. T. MacEachern, Dr. Wendell Phillips and others. He stated that the closed hospital was probably better for teaching purposes but that the open hospital was preferred for general hospitals so that all of the physicians of the community could have some hospital connection. Dr. Allen Craig, associate director, American College of Surgeons, Chicago, followed and spoke upon staff organization and staff appointments.

The other three speakers on this program were not heard until later in the week on account of the lateness of the hour. They were Dr. P. J. Kearns, Montreal, Dr. Stanley T. Fortune, Cambridge, N. Y., and Thomas F. Dawkins, superintendent United Hospital, Port Chester, N. Y.

Workmen's Compensation Discussed

The Tuesday afternoon session was given over to the discussion of the problems of workmen's compensation. Dr. Frank D. Jennings, Brooklyn, N. Y., was the first speaker of the afternoon session and presided at the symposium. Charles Deckelman, manager, claims department, Travelers' Insurance Company, Hartford, Conn., was the next speaker. He traced the origin of the compensation laws and briefly outlined the laws in various states. He stated that the compensation laws meant that everyone had to forego some advantage so that justice could be averaged for all.

George A. Kingston, Industrial Commissioner for the Province of Ontario, Toronto, was the next speaker. He told of the laws in his province and how they were working out generally. Henry D. Sayer, New York, formerly industrial commissioner of New York State, pointed out some differences between the old laws and the new laws. Dr. E. MacD. Stanton, Schenectady, N. Y., stated that what was needed was immediate relief for the injured workman and to that end there should be good ambulance service.

Dr. Frederick J. Tees, Montreal, stated that while Quebec had been the first to adopt a workmen's compensation law, provision had not yet been made for payment of medical and surgical fees, but he hoped that the new laws to come into effect next April would remedy these matters. Dr. C. W. Munger, superintendent, Grasslands Hospital, Valhalla, N. Y., spoke upon the reception of the injured workman at the hospital and said that he believed the employer should tell the workman the basic principles governing the law so that they would know what to expect. "The insurance company and the employer should recognize that no hospital has the responsibility of giving free treatment to the injured workman," stated Dr. Munger.

J. Frank Scannell, counsel for the Federal Mutual Liability Insurance Company, Boston, and John P. Frey, president, Ohio Federation of Labor, Cincinnati, discussed Dr. Munger's paper.

This session was also a long one and the following speakers were heard in addition to the above: Dr. Fred H. Albee, New York; Dr. Ernest A. Sommer, Portland,

Ore.; Dr. George G. Davis, Chicago; William Foster, Syracuse, N. Y.; W. G. Phillips, Baltimore; Dr. Andrew McBride, Baltimore, and Matthew O. Foley, managing editor, *Hospital Management*, Chicago.

Much of the time of the other days was spent in demonstrations at the hospitals of Montreal.

H. E. WEBSTER DIES—TWENTY-TWO YEARS HEAD OF ROYAL VICTORIA

Henry Edward Webster, for the past twenty-two years superintendent, Royal Victoria Hospital, Montreal, Que., died October 29, after a short illness, at his residence in the hospital. Mr. Webster was fifty-three years old and the past thirty years of his life were spent in the service of the Royal Victoria Hospital. He served eight



The late H. E. Webster.

years as assistant superintendent and then was promoted to the superintendency.

During the past twenty years Mr. Webster has taken an active part in hospital work outside his own institution, having been an active member of the American Hospital Association since 1904. He was elected first vice-president of the association in 1914 and in 1920 and from 1921-23 was a member of the board of trustees of the association. In 1921 he also became a life member of the association.

He was born in England and was educated there, coming to Canada in 1893. His brother was the late Alfred George Webster of Golcar, Yorkshire, and his five sisters also reside there. He is also survived by his wife and daughter.

Coming of medical stock, Mr. Webster, although not a medical man himself, found his strongest interest in everything pertaining to the medical field and strove continually to promote the medical as well as other departments of the hospital to their present high standing.

COLORADO HOLDS JOINT MEETING WITH STATE MEDICAL AND CATHOLIC ASSOCIATIONS

THE recent annual meeting of the Colorado Hospital Association, held at Colorado Springs, took the form of a joint meeting of the state hospital association, the state medical association and the Mountain States Conference of the Catholic Hospital Association of America. The joint meeting was so successful, from every standpoint, that it was decided to continue this type of meeting in the future.

Officers elected for the Colorado Hospital Association for the coming year are: President, Dr. G. Walter Holden, medical director, Agnes Memorial Sanatorium, Denver, (re-elected); first vice-president, Dr. H. A. Green, medical superintendent, Boulder Sanatorium, Boulder (re-elected); second vice-president, Sister Francis Joseph, St. Joseph Hospital, Denver, and treasurer, F. J. Walter, Colorado General Hospital, Denver. Dr. Edgar A. Bocock, superintendent, Colorado General Hospital, Denver, will continue as executive secretary.

The trustees are Sister M. Ignatius, Mercy Hospital,

the necessity of further treatment after the tuberculous sanitaria had released their cured patients to society.

F. R. Carpenter, Hayden, Colo., gave an interesting paper on "The Place of the Modern Hospital in a Small Town," characterizing the ideal hospital that is able to keep its debts paid and is on a sound financial basis.

Arthur H. Carhart, landscape architect, Denver, addressed the association on the subject "Beautifying the Hospital by Appropriate Landscaping," pointing out that the harsh lines that have rather predominated in hospital buildings in the past, can be eradicated and made more pleasing to the eye by a small amount of proper landscaping. Dr. H. A. Green, superintendent, Boulder Sanatorium, Boulder, read a paper on the benefits of physiotherapy in institutional work when properly prescribed by a competent physician. The Rev. Joseph Higgins, Pueblo, regional director, Catholic Hospital Association of America, addressed the assembly, stressing especially the fact that hospitals should make public their charitable



A group of members attending the second annual convention of the Colorado Hospital Association held with the Rocky Mountain Conference of the Catholic Hospital Association of America and the Colorado State Medical Society. In the foreground are Dr. H. B. Green, vice-president, Father C. B. Moulinier, president, Catholic Hospital Association of America, Rev. Jos. E. Higgins, regional director, Catholic Hospital Association, and Dr. Edgar A. Bocock, executive secretary, Colorado Hospital Association.

Denver; Mrs. H. E. Greenamyre, Larimer County Hospital, Fort Collins; Dr. R. W. Corwin, Minnequa Hospital, Pueblo; J. E. Swanger, Modern Woodmen of America Sanitarium, Woodmen, and Dr. Edgar A. Bocock.

All the sessions of the convention were held in the Municipal Auditorium, where the large exhibit of hospital products, including booths of about twenty commercial exhibitors, was also held. In the absence of Dr. G. Walter Holden, on account of illness, the meetings were presided over by Dr. H. A. Green, first vice-president.

The business session, at which were presented the reports of the trustees, executive secretary, treasurer and of the program, purchasing, constitutions and by-laws, legislative, auditing and membership committees, was followed by the address of the president and a short talk by Dean C. Lewis, Johns Hopkins Hospital, Baltimore, Md., representing the Colorado State Medical Association. Through a previous arrangement two speakers from the medical society addressed the hospital conference while two from the hospital meeting addressed the meeting of the state medical society.

The afternoon session was devoted to the reading of papers of vital importance and interest to those present. Dr. R. A. Bendove, superintendent, Ex-Patients' Tuberculosis Home, Denver, a member of the association, read a paper on "The Significance of Institutions for Post-Sanitarium Care for Tuberculous Patients," pointing out

work. He brought out that certain hospitals under his jurisdiction were doing thousands of dollars of charitable work every year for which the community gave them no credit, and placed the blame for this condition upon the hospitals themselves. He advocated a system of accounting which would properly record the amount of this work.

The annual dinner meeting, which was in the form of a social gathering, was held at the Broadmoor Hotel. Dr. Franklin G. Ebaugh, director, Psychopathic Hospital, Denver, gave a brief address, explaining to the delegates what the function of such a hospital is and what its place would be in the future hospital organization. Hon. Oliver H. Shoup, Colorado Springs, addressed the delegates from the layman's viewpoint of the present day hospital.

Wednesday's meeting was opened by an address by Father C. B. Moulinier, S.J., president, Catholic Hospital Association of America, who took as his subject the problem to which he has given much study, "The Training of the Hospital Executive." Father Moulinier spoke with enthusiasm, and the entire delegation expressed its approval of his plan.

This address was followed by a round table on a few problems of hospital management, conducted by George A. Collins, superintendent, Denver General Hospital, Denver. The following topics were discussed: "The Hospital of the Twentieth Century," presented by Mr. Martin Higgins,

architect, Denver; "Community Relationship—The Hospital's Part in Health Service," by John E. Swanger, superintendent, Modern Woodmen of America Sanatorium, Woodmen; "Business Administration—The Role of the Purchasing Agent in the Modern Hospital Organization," by Frank J. Walter, Colorado General Hospital, Denver; and "Professional Administration—A Working Relationship Between the Administration and the Hospital Staff," by the Rev. Demetrius Tillottson, superintendent, Presbyterian Hospital, Denver.

At the afternoon session the following topics were discussed: "The Need for Metabolic Facilities in Modern Hospitals," by Dr. Carl S. Gydesen, Colorado Springs; "Social Service—the Liaison Between the Hospital and the Community," by Mary Chew, Children's Hospital,

Denver; "What the Public Health Nurse Can Do to Make Hospital Service More Valuable," by Mrs. Kathryn Schukin, superintendent, Instructive Visiting Nurses' Association, Denver; "The Need for Nurses Trained in Nursing Tuberculosis," by Dr. I. D. Bronfin, National Jewish Hospital for Consumptives, Denver; "The Desirable Attitude of a Hospital Superintendent Toward the Training School of Nurses," by Sister Frances Joseph, mother superior, St. Joseph's Hospital Denver. This round table proved instructive and the interest in every question presented was shown by the large number who entered into the discussion after each paper.

The evening was devoted to a short business meeting, at which the election of officers was the principal matter considered.

INSIGNE COMMITTEE MAKES REPORT

The committee on hospital insigne has submitted the following report to the trustees of the American Hospital Association:

"The question of a worthy insigne to be used by the American Hospital Association and the hospitals throughout the country was, in 1923, submitted to the trustees of the association who carefully considered the matter and agreed that such an emblem should be adopted. The trustees, however, could not go into the subject fully, owing to other pressing needs in the hospital field at that time.

"During the early part of 1926, in order to bring the subject before all hospital officials and others interested in the progressive betterment of hospital service, THE MODERN HOSPITAL published an editorial on the topic, requesting the readers to express approval or disapproval. A great deal of interest was manifested, but nothing practical was offered.

"The matter was again taken up with the President of the American Hospital Association and a committee composed of Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati; Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago; Mr. Tom Jones, artist anatomist, of the Medical School of the University of Chicago; and John A. McNamara, managing editor, THE MODERN HOSPITAL, Chicago. This committee gave a great deal of time to the subject and, through THE MODERN HOSPITAL, notices were sent out to about forty artists and architects to submit designs in competition. Also, a notice inviting hospital people to compete was published in THE MODERN HOSPITAL. This resulted in the receipt of a large number of designs, some of them from the leading designers of the country. These were exhibited at the Atlantic City Convention and a vote was taken by the members and the committee is turning this over to the association together with the emblems. The vote taken was to determine the sentiment of hospital people generally on the insigne and it was understood at that time that the result was in no way final but was merely to stimulate interest.

"The committee recommends that, in the final selection of an insigne, it should be very simple in design, it should be distinctive, it should be the heraldic device of the entire hospital field, there should be nothing in it to offend any religious faith, it should be dignified and capable of artistic development, it should breath the altruism, kindly sympathy and hope that animate the hospital field, it should be readily adaptable to the use of hospital associations, hospitals, training schools, as a nucleus for their insignia,

and it should be as accurately symbolic as the Scales of Justice.

"Therefore, we, the committee, further recommend that the board of trustees of the American Hospital Association appoint another committee to take over the work that THE MODERN HOSPITAL and its committee has done to date and bring it to a conclusion, the new committee to be representative of the Catholic Hospital Association, the Protestant Hospital Association, there should be a Canadian representative, a representative of the orthodox Jewish hospitals, and of the American Hospital Association, this committee to secure in cooperation the following artists: Messrs. Robert Harshe, director, Art Institute, Chicago; Gerald Page-Wood, vice-president and director, Erwin Wasey Adv. Co., Chicago; T. M. Cleland, artist and designer, New York; John Norton, artist, Chicago; Lorado Taft, sculptor, Chicago, and Fred W. Goudy, artist and designer, New York.

"We further recommend that the instructions that THE MODERN HOSPITAL sent to the various artists who submitted designs be fully considered by the judges in making their selection."

STRONG MEMORIAL IS DEDICATED— FOLLOWED BY CONFERENCE

More than a hundred representatives of hospitals, medical schools, universities and other institutions from America and from European cities attended the dedicatory exercises of the University of Rochester School of Medicine and Dentistry and of Strong Memorial Hospital, Rochester, N. Y., October 25.

The dedication of the hospital in the afternoon opened with a short address by President Rush Rhees, of the University. Mrs. Gertrude Strong Achilles was presented with the keys by President Rhees and she in turn presented them to Dr. Nathaniel Faxon, director of the hospital. The building was given by Mrs. Achilles and Mrs. Helen Strong Carter in memory of their father and mother, Henry Alvah and Mrs. Helen Griffin Strong.

Following the dedication a scientific conference was held at the medical school that was attended by many medical men of prominence. Among the speakers was Dr. Ludwig Hecht, head of the department of pathology, Rush Medical College, University of Chicago, Chicago, who read a paper on the results of investigations in tuberculosis, measles and scarlet fever made in the John McCormack Institute for Infectious Diseases, Chicago.

Personals

DR. B. RUSH FIELD has succeeded **DR. EDWIN R. LEWIS** as superintendent of the Easton Hospital, Easton, Pa. Dr. Field is a graduate of the University of Pennsylvania Medical School, Philadelphia, and since his graduation has practiced medicine in Easton.

DR. JOHN D. SPELMAN, superintendent, Touro Infirmary, New Orleans, La., was elected president of the newly organized Southern Hospital Association, formed at the recent meeting of the Alabama Hospital Association, held at Mobile.

DR. EDGAR ALLEN, Elyria, Ohio, has been chosen to direct a state-wide campaign in Arkansas toward the erection of a hospital for the crippled children of the state.

ANNE JERDE has tendered his resignation as superintendent of the Ashton Memorial Hospital, Pipestone, Minn. She has been superintendent of the hospital since its opening.

DR. EDGAR A. BOCK and **DR. MAURICE H. REES** have been reappointed by the board of regents of the University of Colorado, Denver, for another year as superintendent of the University Hospital, and dean of the medical school, respectively.

DR. J. E. GROFF, Rome, N. Y., has been elected president of the board of trustees of the Murphy Memorial Hospital, Rome, N. Y.

DR. BIRKHEAD MACGOWAN has resigned as superintendent of the Sydenham Hospital, Baltimore, Md., to accept a position in Washington, D. C. He will be succeeded at the Sydenham Hospital by **DR. MYRON G. TULL**, assistant physician of the hospital.

DR. ELLIS L. SMITH has been appointed superintendent of the Essex County Hospital for Contagious Diseases, Belleville, N. J., succeeding **DR. FRED A. PRINGLE** who resigned in May. Dr Smith has been serving as acting superintendent since that time.

DOROTHY HAZLETON, Greentown, Pa., has assumed the duties of superintendent of the General Hospital, Carbon-dale, Pa., succeeding **MRS. LYDIA THOMAS** whose resignation became effective October 1. Miss Hazleton is a graduate of the State Hospital, Scranton.

DR. ROY W. BENTON, New Bedford, Mass., has been appointed first assistant superintendent, City Hospital, Providence, R. I., succeeding **DR. HARMON P. B. JORDAN** who is becoming superintendent of the new Lying-in Hospital, Providence. Dr. Benton is a graduate of Harvard Medical School, Boston, and has been second assistant superintendent of the City Hospital, Providence, for the past year.

SISTER M. CYRIL has been appointed superintendent, St. Francis' Hospital, Poughkeepsie, N. Y., to serve in this capacity for the next six years. **SISTER ANTOINETTE** who has served the hospital as superintendent for the previous six years, has taken up similar duties at the Port Jarvis Hospital, Port Jarvis. Sister Cyril has been with the institution for the past twelve years.

ADA F. ADAMS, formerly superintendent of the Nassau Hospital, Mineola, L. I., for thirteen years, and recently superintendent, Framingham Hospital, Framingham, Mass., is the new superintendent of St. John's Hospital, Yonkers, N. Y., succeeding **OLIVE LUESSLER**, who recently resigned. Miss Adams is a graduate of the Massachusetts General Hospital, Boston.

MARGARET GILES was recently appointed superintendent, Sanchez Private Sanitarium, Barwick, Ga. Miss Giles was formerly with the U. S. Veterans' Hospital, Alexandra, La.

WILLIAM D. BAXTER, formerly assistant superintendent, New York Hospital, New York, assumed the duties of superintendent of the Peekskill Hospital, Peekskill, N. Y., last month.

DR. GEORGE McL. WALDIE, formerly superintendent, Buena Vista Sanatorium, Wabash, Minn., is now associated with the Houghton County Sanatorium, Houghton, Mich.

MRS. EDITH M. WALKER is the new superintendent of the Great War Memorial Hospital, Perth, Ont. Mrs. Walker was formerly connected with the Carleton General Protestant Hospital, Ottawa, Ont.

DR. C. W. SCHIEB, Bucyrus, Ohio, has been appointed governing physician of the Workhouse Hospital, Welfare Island, N. Y. Dr. Schieb was formerly with the Mayo Foundation, Rochester, Minn., and with the Metropolitan Hospital, Welfare Island.

RUTH I. HUMPHREYS, for five years assistant superintendent of the Newton Hospital, Newton, Mass., has been appointed superintendent of the Framingham Hospital, Framingham, Mass., succeeding **ADA F. ADAMS**, resigned.

DR. ADOLF MEYER, director, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, has been elected president of the Mental Hygiene Society of Maryland, to succeed **DR. EDWARD N. BRUSH**.

SISTER LUCIA, a member of the Order of Sisters of Charity of Saint Vincent de Paul, St. Joseph's Hospital, Chicago, recently celebrated her fiftieth anniversary in the Order. She has been superintendent of nurses at St. Joseph's Hospital for the past twenty-three years.

DR. CORNELIA W. SEGAR has been appointed medical director of the Piedmont Sanatorium, Piedmont, Va., to succeed the late **DR. HARRY G. CARTER**.

DR. G. S. ADAMS, superintendent, State Hospital, Yankton, S. D., recently entertained the district medical society at the state hospital. The meeting was also attended by a large delegation of medical students from the University of South Dakota.

EDITH L. BURNS, superintendent, Braddock General Hospital, Braddock, Pa., died of heart failure, October 25. Miss Burns had been at the Braddock Hospital eight months and previous to that time had been superintendent of the Rome Hospital, Rome, N. Y., for over seven years. She will be succeeded by **GRACE SCOTT**, who has been directress of nurses at the Braddock Hospital.

J. Z. KERR has assumed the superintendency of the Ohio Valley Hospital, Steubenville, Ohio. He was formerly superintendent of the Huron Road Hospital, Cleveland.

NAIUMA CLARK, who has been superintendent of the Polk County Hospital, Bartow, Fla., has tendered her resignation. For the present, **DR. HARGRAVES**, county physician, will assume the work of superintendence.

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ILLINOIS GRADUATE NURSES CELEBRATE TWENTY-FIFTH ANNIVERSARY

A LARGE group of nurses from the fourteen districts of the state attended the twenty-fifth anniversary meeting of the Illinois State Association of Graduate Nurses, held in Chicago, October 20-23. The meeting was featured by a number of addresses of outstanding leaders in the field and their messages gave encouraging indication that both the profession and the public are making an intelligent effort toward the end of solving the nursing problem, according to Minnie H. Ahrens, director, Central Bureau and Nurses' Registry, Chicago.

The interest that Illinois nurses are taking in furthering the education of members of the profession had definite expression in their pledge of \$4,000, by members during the meeting, as a part of the aggregate sum of \$25,000 that the nurses of the state have pledged to be used for some form of nursing education at the University of Chicago.

Form Branch of National Association

Another significant outcome of the meeting was the completion of the plans formed a year ago, for the organization of the Great Lakes Branch of the American Nurses' Association. The proposed branch will include the five states, Michigan, Illinois, Indiana, Iowa and Wisconsin. These states have expressed their intention of joining the group and a formal application is soon to be made to the national headquarters of the association for the establishment of this branch. The other branches of the association are the New England branch, the Mid-Atlantic branch and the Northwest branch. It is planned to have the Great Lakes Division under a directorate of fifteen members, three members from each state, and the officers of the branch will be elected by the board of directors.

The officers for the coming year are president, Irene Stimson, instructor in hygiene, Rockford College, Rockford; first vice-president, Mary Cutler, educational supervisor, Presbyterian Hospital School of Nursing, Chicago; second vice-president, Sarah Place, superintendent, Infant Welfare Department, Chicago; secretary, May Kennedy, superintendent, Illinois State School of Psychiatric Nursing, Chicago; treasurer, Elizabeth Asseltine, superintendent of nurses, Children's Memorial Hospital, Chicago. The next meeting, to be in October, 1927, will be held at Mount Vernon, Ill.

The chairmen of committees for the coming year are: Credential, Fanny Brooks, department of health, University of Illinois, Urbana; finance, Mabel Dunlap, director of public health nursing, Moline; legislative, Alice Dalbey, Springfield Hospital School of Nursing, Springfield; nominating, Anna Cole Smith, Wesley Memorial Hospital School of Nursing, Chicago; program, Mabel Shields, instructor in nursing, Aurora Hospital, Aurora; publicity and press, Katherine Densford, Illinois Training School for Nurses, Chicago; Red Cross, Mary Garretson, Community Nursing Service, Winnetka; relief, Lillian Thompson, superintendent of nurses, Community Hospital, Geneva; revision of constitution and by-laws, Charlotte Johnson, superintendent of nurses, Annie W. Durand Hospital, Chicago; tuberculosis, Alice Hafner, Juvenile Court, Chicago.

One of the outstanding speakers of the meeting was Annie Goodrich, dean, Yale University School of Nursing, New Haven, Conn., who outlined the work that is being accomplished in nursing education. Dean Goodrich also

stressed the value of group nursing and the hourly service as the two types of nursing that must be developed to meet the problem of the high cost of nursing.

Another address that was received with much enthusiasm was that dealing with the problems in grading of schools of nursing, delivered by May Ayres Burgess, Ph.D., director of the committee on the grading of schools of nursing, New York. Dr. Burgess presented the analysis of the work of the committee, illustrated by charts, similar to the talk she gave at the recent meeting of American Hospital Association. She said that the work of the committee thus far showed definitely the need for organizing courses to train superintendents of training schools and for making the position of superintendent sufficiently attractive to induce women to remain in that position permanently.

Many leaders of the profession, from various parts of the country, were present at the banquet session, among them being, Adda Eldridge, ex-president, American Nurses' Association, Madison, Wis.; Elizabeth Gordon Fox, national director, Public Health Nursing Service, American Red Cross, Washington, D. C.; Evelyn Wood, president, Central Council for Nursing Education, Chicago, and Minnie Ahrens, Chicago. Among the hospital superintendents present were Asa S. Bacon, Presbyterian Hospital, E. S. Gilmore, Wesley Memorial Hospital and Dr. Herman Smith, Michael Reese Hospital, all of Chicago.

ONTARIO ASSOCIATION MEETS

The hospital as a center of preventive medicine, heliotherapy, standardized accounting for hospitals, community support and nursing problems were some of the important subjects discussed at the recent annual convention of the Ontario Hospital Association, held at Toronto.

Some of the features of interest were the round table conference on dietary problems, procedures for operating and anesthesia departments, a round table for trustees and one for nurses. Many of the papers read were on technical and administrative procedures. The meeting also included demonstrations, one of which was on admitting office procedure and record room technique. Another held at the Toronto Western Hospital, was on the Schick and Dick tests and other technique pertaining to recent bacteriological experiments.

The following officers were re-elected for the coming year: President, Major G. G. Moncreiff, Petrolia; first vice-president, Dr. W. J. Dobbie, Weston; second vice-president, Major A. H. Murphy, London; honorable secretary-treasurer, Dr. F. W. Routley, Toronto.

KANSAS ASSOCIATION HOLDS ANNUAL MEETING

The twelfth annual meeting of the Kansas Hospital Association was held recently at the Axtell Christian Hospital, Newton. The following program was presented at the meeting: an address on nutrition, by Dr. J. T. Axtell, Newton; "Little Foxes," by Mrs. N. E. Flowers, Newton; "Relation of the Laboratory to the Hospital," by Dr. Watson Campbell, Halstead; "Relation of the Full-Time Health Officer to the Hospital," by Dr. J. S. Fulton, Emporia. The meeting also featured a round table conducted by Dr. P. C. Young, Arkansas City.

EDUCATION OF PRACTITIONERS STRESSED AT PHYSICAL THERAPY CONGRESS

ALL aspects of the science of physical therapy were discussed at the clinical congress of physical therapy held in conjunction with the fifth annual meeting of the American College of Physical Therapy, held at the Drake Hotel, Chicago, October 18-23, 1926.

The keynote to the entire meeting and to the objectives of the association was sounded in the presidential address, "The Future of Physical Therapy," delivered by Dr. John Stanley Coulter, Chicago. That the future of physical therapy is a question of education and of an intelligent application of the physical agencies in combination with medicine and surgery was strongly brought out by Dr. Coulter. He advocates that medical schools establish special sub-departments of physical therapy as a division of medicine and that a series of compulsory lectures, with six one-hour lessons as a minimum, be required of medical students.

He believes that to insure a permanent place for this branch of medicine the physicians of the country will have to be educated to realize its place among the therapies. This can be done by four methods, which he enumerated, namely, through medical society meetings; by clinics; through medical journals, and by post-graduate instruction. In the last educational number of the *Journal of the American Medical Association*, Dr. Coulter said that there are only five schools listed as giving post-graduate instruction for physicians. He also emphasized the need for the training of competent technicians to assist in the application of treatments, but brought out clearly that under no circumstances should any but a qualified physician assume the head of a physical therapy department. He urged medical societies to work toward the end of establishing requirements that compel hospitals to have a physician in charge of the physical therapy department.

Advocates Registry for Physiotherapists

Dr. Coulter also advocated the establishment of an American registry for physical therapy technicians along the lines of the American Registry for Radiological Technicians so that technicians may correlate their vocation as a subsidiary to physical therapy. To further the registry he suggested a board of six members who should pass upon the acceptability of candidates for the registry, arrange for examinations, seek to effect the registrations of all technicians by proper state laws and serve as a source of information. These men are to be chosen from the American Colleges of Medicine, Surgery, and Physical Therapy and the various physical therapy societies.

The hospital aspects of physical therapy were handled in a paper, "The Status of the Physical Therapy Department in the Modern Hospital," by Dr. William H. Walsh, executive secretary, American Hospital Association, Chicago, who discussed the subject from the standpoint of the hospital administrator.

Dr. Walsh laid a great deal of emphasis upon the necessity for placing a trained physician as head of the department as the wisest policy not only from the standpoint of treatment but also from the standpoint of the equipping and managing of the department.

Dr. Walsh said that many controversies had arisen over the question of who shall prescribe treatment. He feels that the correct answer to the problem is that the attending physician should prescribe all treatment but that in the application of physical forces, the prescription

should always be carefully checked up by the head of the physical therapy department. Then if the head of the department does not agree with the attending physician as to the amount or kind of treatment, he is free to make suggestions and if this procedure does not prove satisfactory a consultation of staff members should be called when there is any suspicion of the modality.

The equipment for the department, he said, should include all apparatus adequate for the treatment by electro, hydro, radio and mechanotherapy. He laid particular emphasis upon the need for cooperation from this department in maintaining adequate records of the work done.

The last morning of the conference was spent in clinics held at the various Chicago hospitals as follows: hay fever and asthma, conducted by Dr. A. R. Hollender, and partial deafness, by Dr. M. H. Cottle, at the American Hospital; general physical therapy, by Dr. John Stanley Coulter, at Cook County Hospital; industrial physical therapy, by Dr. Paul Magnuson at Wesley Memorial Hospital, and surgical diathermy, by Dr. D. Kobak, at Cook County Hospital.

SOCIAL WORKERS HOLD TWO-DAY DISTRICT MEETING

Hospital social workers from Cleveland, Pittsburgh, Pa., and Buffalo, N. Y., attended the district meeting of the American Association of Hospital Social Workers held in Rochester, N. Y., November 5 and 6.

The meeting opened with a business session of the Central District held at Rochester General Hospital. Lydia Clarke, Marine Hospital, Buffalo, was chosen chairman of the district to fill the vacancy caused by the resignation of Elizabeth Cosgrove, Mercy Hospital, Pittsburgh. Other officers elected were secretary, Katherine Ham, Strong Memorial Hospital, Rochester, and treasurer, Mrs. Grace Littman, Lakeside Hospital, Cleveland.

One of the features of the meeting was a round table on "The Interpretation of Social Service to Pupil Nurses," with Agnes H. Schroeder, Lakeside Hospital, Cleveland, leader.

The afternoon session took the form of an open meeting presided over by Ida M. Cannon, chief, social service department, Massachusetts General Hospital, Boston.

Elizabeth Lowry, social service department, Rochester General Hospital, Rochester, was the leader of a discussion on the subject, "Relationships between Social Service Departments and Women's Committees." Mrs. William J. Baker described the work done by volunteers at Rochester General Hospital. Mrs. Charles W. Webb, Lakeside Hospital, Cleveland, president, American Association of Hospital Social Workers, reported from the national association.

INDUSTRIAL NURSES ADDRESSED ON WORKMEN'S COMPENSATION

Joseph A. Parker, Massachusetts Industrial Accident Board, was the speaker at the recent meeting of the New England Industrial Nursing Association, held in Boston, Mass. Mr. Parker is the oldest member of the board and as a member of the state legislature presented the workmen's compensation act to that body in 1905. However, the law was not accepted and did not become workable until July 1, 1912. Mr. Parker summarized the industrial compensation work of the state.

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PUBLIC HEALTH MEETING HAS RECORD ATTENDANCE

One of the largest attendances that has ever featured a health meeting was that at the fifty-fifth annual meeting of the American Public Health Association, held at Buffalo, N. Y., October 11-15. The meeting totalled more than 1,300 registrations. The convention was under the direction of Dr. C.-E. A. Winslow, professor of public health education, Yale University, New Haven, Conn.

Officers for the year were elected as follows : President, Dr. Charles V. Chapin, superintendent of health, Providence, R. I.; first vice-president, Dr. Herman N. Bundesen, commissioner of health, Chicago; second vice-president, Dr. A. T. Douglas, health officer, Winnipeg, Man.; third vice-president, Dr. F. E. Fronczak, health commissioner, Buffalo, N. Y.; treasurer, Dr. Louis I. Dublin, Metropolitan Life Insurance Company, New York.

Louisville Chosen for Next Meeting

Louisville, Ky. was chosen as the next meeting place. In his presidential address Dr. Winslow drew a vivid picture of the accomplishments of health work and of the problems that confront health workers. "Public health formerly rested on social science," said Dr. Winslow, "but the time has come to determine where the social care of the individual must cease and where he must assert his own responsibility. He brought out that curative and preventive medicine were more and more overlapping and that in a few years their boundaries would be indistinguishable. He stressed that public health problems would be solved by drawing on the medical profession. Health centers, he said, were becoming more important as a part of the general health program, but that what form organized medical service would take was yet to be determined.

Among the significant resolutions adopted by the convention was the one endorsing the principles of the Parker bill for the reorganization to Federal health activities. The association also endorsed the efforts to continue for two years the appropriation by congress of funds to be expended for maternal and infant hygiene. The need for better organized medical service for the checking of incipient diseases was emphasized in another resolution asking the committee on administrative practice of the association to cooperate with appropriate representatives of the American Medical Association in an endeavor to develop such an organization. Other resolutions endorsed the work of the National Congress of Parents and Teachers in its effort to secure physical examinations of all pre-school children and also favored the placing of regional sanitary engineers in the U. S. Public Health Service on the same commissioned status and with the same travel allowances as the regular medical officers in the service.

The section on health education and publicity held several clinics at its meetings for the discussion of posters from their scientific, artistic and psychological appeal. The name of the section was changed to the public health education section, in order more nearly to express the purposes of its work.

Workmen's compensation and industrial hygiene received considerable discussion at the meeting. Pertinent questions facing the field of industrial hygiene today were discussed by Dr. F. L. Rector, editor, *Nation's Health*, Chicago. Chief among the problems, he said, were the lack of facilities for adequately training physicians and nurses for industrial work. Dr. Rector brought out that morbidity statistics have not been gathered and analyzed as they should have been and that industrial medical men

must learn that their work is but one branch of the larger public health activity and as such its chief claim to recognition is in the field of prevention rather than cure.

Several special sessions were held during the convention at which health teaching in colleges, rural health work, ventilation, milk and mental hygiene were discussed.

PLAN FORMATION OF NURSES' PENSION SYSTEM

Preliminary plans for the establishment of a pension system for graduate nurses are being formed by the Harmon Foundation, New York, in cooperation with other agencies. It is intended to develop the retirement annuity for members of the nursing profession and the administration of the fund will rest with an advisory committee of the Nurses National Annuity Association and some insurance organization, and the fund itself will be established and maintained by the contributions of each nurse and her employer.

The plan, as tentatively outlined, provides for a weekly payment during periods of employment of one dollar from a nurse who is to receive an annuity. A surcharge of two dollars a week would be made to private patients who employ a nurse for short periods. Where the period of nursing is for one year or longer it is expected that the surcharge would be about one dollar a week.

If these payments are kept up over a period of thirty years it is expected that a retirement allowance of about \$1,400 a year can be paid to superannuated nurses. Death benefits and withdrawal payments are being considered, and plans are being formulated for carrying out these procedures.

The association and its activities will be organized under the auspices of the Harmon Foundation which purposes, if necessary, to set aside the sum of \$50,000 to be used as required for organization, including publicity and other expenses.

The mechanical details of the plan have not yet been worked out and will be announced as soon as they are in definite shape.

DR. ROBERT J. WILSON DEAD

Dr. Robert Justice Wilson, New York, who was well known to hospital people, died October 16. Dr. Wilson was president of the Association in 1917, a member of the board of trustees from 1919-23 and acted as treasurer during 1922-23.

He was born in New York in 1866, was graduated from Bellevue Medical School in 1890 and was associate professor of bacteriology and hygiene of the New York University and Bellevue Hospital Medical College for several years, director of the health department's hospitals, and a member of the staff of Willard Parker and Reception hospitals.

TWENTY-FIVE MILLION DOLLAR HEALTH CENTER PLANNED FOR CHICAGO

A twenty-five million dollar health center with facilities for 4,000 patients, on Chicago's lake shore, has been proposed as a part of the institutional features of the centennial celebration to be held in Chicago, in 1933. The institutional part of the exposition will have twenty-five units, according to a recent announcement of Edward N. Hurley, chairman of the centennial committee, and the health center will be a model of scientific equipment and treatment.

NEW YORK'S COMMUNICABLE DISEASE HOSPITALS APPROVED

The Department of Health of New York City announces that the hospitals of the city for the care and treatment of the communicable diseases have been approved by the American College of Surgeons, following the survey recently made by the standardization committee. The reorganization of these institutions has been going on for the past three years under the direction of Dr. S. W. Wynne, director, Bureau of Hospitals, New York.

The department also announces that the State Board of Nurse Examiners has approved the training school that has been established at Willard Parker Hospital, New York, where nurses of affiliated schools will receive a training in the acute contagious diseases and public health nursing. The school opened on October 1 and on October 15 had thirty-nine students in attendance. At present, there are eleven training schools affiliating with Willard Parker Hospital.

CONFERENCE ON HEALTH EXAMINATIONS HELD BY A. M. A.

Another conference on periodic health examinations of the apparently well was held by the house of delegates of the American Medical Association, November 20, Chicago. The meeting was held in conjunction with the annual conference of secretaries of state medical societies and was open to all members of the American Medical Association.

Dr. Robert M. Schauffler, president, Kansas City Health Association, Kansas City, Mo., spoke on "Educating the Physician for Public Health Speaking and for Periodic Health Examinations," and Dr. W. S. Leathers, department of preventive medicine, Vanderbilt University, Nashville, Tenn., spoke on "The Education of Undergraduate Medical Students in the Matter of Periodic Health Examinations."

Reports were given by the executive secretary, Bureau of Public Health and Public Instruction, and general discussion followed on the best means of promoting this type of medical service.

JANET GEISTER APPOINTED DIRECTOR OF NURSES' ASSOCIATION

Janet Geister, R.N., assistant secretary of the Associated Out-Patient Clinics of New York City and executive secretary, Association of Tuberculosis Clinics, has been appointed director of the American Nurses' Association, to succeed Agnes G. Deans. Miss Geister will assume her position on January 1.

In 1925, Miss Geister was a member of a committee which made the study of private duty nursing in New York state, the results of which showed that out of the 1,409 nurses who answered the questionnaire, the average private duty nurse in a peak week of illness earned only 49 cents an hour, approximately the amount received by charwomen, servants and unskilled labor.

BEQUESTS LEFT BY DECEASED MEMBERS OF WOMEN'S BOARD

Three members of the women's board of the Youngstown Hospital, Youngstown, Ohio, who have died during the past half year have left bequests for the benefit of the hospital. Mrs. Anna Todd, president of the board, left

\$5,000; Mrs. T. J. Harrington left \$10,000 for an endowment and Lucy Buechner left a half million dollars for a building to be known at the Buechner Memorial, to be used for orthopedic surgery.

Miss Buechner who is the last member of her family in that section was the daughter and sister of two well known surgeons of the city, and the instruments, office equipment and medical books belonging to her family were turned over by her to the hospital. Her bequest to the hospital is approximately 95 per cent of her estate.

The hospital has also recently received \$12,000 from the estate of William G. Pollock, Cleveland, and \$5,000 from J. G. Fernally Bonnell, in memory of his mother.

PLAN PERMANENT COURSE FOR GRADUATE NURSES AT U. OF C.

Plans for a permanent course for graduate nurse study in the curriculum of the University of Chicago, Chicago, were given impetus at the recent meeting of the Illinois League of Nursing Education held in conjunction with the meeting of the Illinois State Association of Graduate Nurses, in Chicago, October 20-23.

Two summer courses have already been given at the university under the auspices of the league and the cooperation of both the university and students has been so gratifying, according to Evelyn Wood, president of the league, that efforts toward the establishment of a permanent course are being made. During the recent convention the Illinois nurses in attendance subscribed over \$4,000 toward financing the project. This sum has been pledged as a part of the goal of \$25,000 to be raised toward financing nursing education at the university.

IOWA HEART ASSOCIATION HAS ACTIVE YEAR

The first annual report of the Iowa Heart Association, recently issued, shows that during the period from July, 1925, to July, 1926, thirty-one county cardiac clinics were held and a total of 326 patients were examined. In 201 of these cases heart disease was the diagnosis. Over 280 physicians were present at these clinics.

Twelve general news articles, syndicated throughout the state, were given a total space of about 10,000 inches in the newspapers; in various communities special local articles were also published.

At the state fair a special clinic was held jointly by the Iowa Heart Association with the Iowa Trudeau Society.

DR. MacEACHERN ADDRESSES ST. JOSEPH'S STAFF MEETING

An address on hospital organization in Australia and New Zealand, by Dr. M. T. MacEachern, associate director, American College of Surgeons, hospital activities, Chicago, featured a recent meeting of the attending and visiting staffs of the St. Joseph's Hospital, Chicago. Dr. MacEachern outlined his recent trip to the above countries, pointing out the interesting features of the New Zealand and Australian hospitals which he visited and illustrated his talk by appropriate lantern slides and charts.

According to a recent report of the bureau of mental health of the State Department of Welfare of Pennsylvania, the state has forty-six mental clinics operated under the auspices of the department. In addition there are several occasional clinics in the public schools.

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

How May the Intern be Stimulated to Secure a Large Number of Postmortem Examinations?

The superintendent of the hospital must first be convinced that his institution is not fulfilling its place in the community unless its postmortem percentage is constantly approaching 40 per cent. The staff must have a like conviction.

New interns must be immediately informed that their efficiency record will contain month by month the percentage of postmortems secured by them on their service. The superintendent, or other medical administrative officer, should on their arrival instruct new interns in the arguments to be employed in securing postmortems.

A monthly postmortem sheet, which gives the percentage of each intern, each visiting chief and each service as well, should be issued. Each visiting chief should be informed at the end of the month of the number of deaths that occurred on his service, and the number of cases posted. Encouraging letters should be sent to those chiefs and interns who have a particularly high rating. Semi-reproachful notes may stimulate greater effort on the part of those who have a low percentage. Those interns who are persistently low in their postmortem percentage should be interviewed by the superintendent or his medical assistant, relative to the reasons for failure so that, if possible, the general average can be increased through individual effort.

Clinical pathological conferences, held at not less than monthly and probably weekly intervals are useful in stimulating interest in getting postmortems.

Not only is the medical personnel of the hospital to be kept at a high point of interest in this matter, but others, such as social workers, nurses and even the clerical force of the office, should be continually urged to do their part in maintaining for their hospital a high percentage of postmortem examinations.

Should the Ambulance Be Supplied With a Gong or an Ordinary Warning Signal?

Most hospital administrators have had the experience of standing on the street corner, and seeing an ambulance from their particular institution, with a clanging gong, dashing by at a speed too great for safety. Upon arrival at the hospital they were disgusted to find upon inquiry that the patient being transported on that particular ambulance call was one whose admission to the hospital was in no way an urgent matter.

In some cities ambulances are given right of way in the same manner as are fire trucks. Advantage being taken of this courtesy the chauffeur endangers the lives of pedestrians by reckless driving through crowded streets. With relatively few exceptions, the difference of a few minutes' time in the arrival of the ambulance at the hospital is never life-saving. Unfortunately, medical science does not often possess the power to revive a patient, whose

life would be lost if his arrival at the hospital had been delayed a few minutes. The gong on the ambulance is useful, if properly used. The difficulty arises in enforcing an observance on the part of the chauffeur of the propriety and need for this warning. The presence of a gong is a continuous invitation to unnecessary speed and to disregard of the traffic rules of the locality in which the hospital is situated.

The superintendent must be continually on the alert to select men of judgment and caution as ambulance drivers.

The ordinary warning signal is usually sufficient to clear the way, and a speedometer, in which a tape records the maximum speed attained at any time by the ambulance, is of use in enforcing observance of proper safety precautions.

If the institution is enabled by the use of this device properly to protect the lives of pedestrians and of patients being conveyed by the ambulance, then it would probably be wise to discard the usual ambulance gong, replacing it with a warning signal such as is found on other cars. Many hospitals in this country have adopted this plan, and have found it both practical and efficient for ordinary purposes.

Does a Man or Woman Make the Best Laundry Supervisor? Where Could a Person Receive Training to Fit Him or Her to Head a Hospital Laundry?

The person who asked this question of THE MODERN HOSPITAL probably had some local reason for so doing.

The larger commercial concerns are usually supervised by a man. Many hospital laundries are so managed. On the other hand, some of the best and most efficiently conducted laundries in the institutions of this country are supervised by women, and oftentimes these persons have had nurse training. It is impossible to give any definite answer to this question. Often a woman possesses attributes that enable her to perform the duties of laundry supervisor in a broader and more efficient way than could a man with equal training. The handling of women help appears to be easier for a properly equipped woman than it is for a man. However, local conditions are a large governing factor in this matter.

Technical training is not always productive of the best administration, but frequently an admixture of a pleasing personality with proper administrative ability, and the soap and water employed in cleansing clothes, produces a most effective result, from the standpoint of giving the hospital plenty of clean linen.

In reply to the second part of this question, we find that the heads of hospital laundries usually have been recruited from the ranks. Occasionally, they have worked in commercial laundries. Problems that arise in doing hospital work are very different from those in extra-institutional plants. It is probable that the best way of

securing information in regard to conducting hospital laundries would be an admixture of experience in commercial and institutional work. Attendance at a school for hospital administration cannot in any way replace the need for a long, practical and thorough experience in the work of an institutional laundry.

How Can Economy in the Use of Supplies be Best Taught to the Student Nurse?

The student nurse is not singled out because she is the only one in the hospital who needs instruction in economy. Much money could be saved by the hospital, however, if each nurse were as careful with the supplies that she handles as she would be if they were bought from the purse of her own family. Too many look upon the question of the use of supplies as if the resources of the institution were unbounded, and the stock of gauze, adhesive plaster and ligatures unlimited. The personal use of the hospital's gauze by nurses is a problem which has disturbed many administrators.

A central surgical supply room, to which all gauze and muslin are delivered, and from which sponges, bandages and other gauze and muslin preparations are issued, is a useful expedient to adopt in preventing the misuse of these articles. The supervision of the supply of ether in the operating and dressing room must be most strict, if the use of this expensive drug for cleaning purposes is to be prevented.

Perhaps one of the best ways of bringing about economy in the use of supplies on the part of the student nurse, is for the directress of nurses to conduct a course of talks, in which the cost of equipment and materials is set forth, and in which methods of conservation are discussed. The superintendent of the hospital can accomplish a great deal along this line, if he makes it a point to take an active part in this course.

A graphic display of the chief articles used in the daily work of the hospital, which might consist of a roll of gauze and one of adhesive plaster, a tube of catgut and some of the commoner surgical instruments, for instance, with a card affixed, plainly setting forth each article's cost, oftentimes is so impressive to young physicians and nurses that they gladly cooperate in any economy program. Indeed, for newly arrived interns and probationary nurses a trip about the institution, during which the cost of supplies is pointed out and the care of equipment and instruments urged, bears fruit in promoting hospital economy.

After all, economy is a result of the development of a property responsibility in the minds of the members of the hospital personnel, and this end can be gained only after prolonged and thorough emphasis has been placed on this subject by the superintendent and his co-workers.

What is the Relation of the Department Head Nurse to the Interns on Duty?

The head nurse is usually the most stable officer in any of the hospital's departments, from the standpoint of length of service, although in institutions where the resident physician system is in vogue, sometimes a physician has almost as long a tenure of office. In most hospital organizations, however, the head nurse is the person who is responsible for the care of hospital property, and for the administrative supervision of the nursing work done in her department.

The young intern in these departments oftentimes must look to the head nurse for much of his information con-

cerning the manner of conducting the day's routine. It is often the experienced head nurse who tactfully informs the young physician of the rules, customs and procedures in her department. It is a wise intern who accepts this information in the spirit in which it usually is given. The head nurse, of course, has no authority in regard to the details of any treatment which may be prescribed for the patient. She has no authority in making new rules governing the work of the intern. Nor is to be denied that she sometimes displays too little tact in passing on to the intern information that she has received from others.

But in the last analysis, many successful physicians received their first instruction in doing dressings in the surgical ward or in performing many other similar duties, from an experienced graduate nurse. Ofttimes, this information was so tactfully imparted that the physician did not realize at the moment that he was being directed by the assisting nurse.

However, friction not infrequently arises between an intern and a graduate nurse, because the former resents any attempt on the part of the latter to inform him concerning departmental rules. When such a situation arises, the superintendent of the hospital and the directress of nurses must settle the dispute in a way that will avoid, if possible, the injection of personalities into the business of treating the patient.

When it comes to the question of the protection of property, and the issuance of supplies for the use of the doctor, the head nurse is usually finally responsible through her directress to the hospital superintendent, and the intern must recognize this fact.

What is the Authority of the Hospital Executive Relative to the Enforcement of Rules Governing Preoperative Urine and Chest Examinations?

A delicate situation arises in many institutions when it becomes necessary for this question to be definitely answered. Usually, where the proper organization of the visiting staff exists, this body legislates against members operating without proper preoperative studies having been made. Most surgical staffs have definite rules in regard to this matter, in conformity with the recommendations of the American College of Surgeons.

On the other hand, it is argued by some surgeons that in the last analysis they are responsible for the patient's welfare, and that no one has a right to interfere in regard to any part of their technique, whether preoperative or postoperative. At times, however, a decision, in regard to waiving the rule requiring preoperative preparation, must be rendered on short notice. The reputation of the hospital is injured, even more than that of the individual surgeon, when postoperative accidents occur and upon the hospital rests the burden of righting these wrongs, insofar as possible.

The superintendent of the hospital is the final resident authority in regard to matters concerning the welfare of the hospital and its patients. It is the belief of most experienced hospital executives that the superintendent does have the authority to insist upon the observance of rules governing all the work of the hospital and the welfare of its patients.

Even though the surgeon could be called to account for accidents that happened because a rule, relative to preoperative preparation, had not been carried out, oftentimes to mete out punishment at this date does not save the patient the inconvenience and danger to which he has been subjected.

It is the superintendent's duty to see that all rules and regulations of the institution, whether promulgated by his medical staff and approved by the board of trustees, or whether originating with the latter body, are conscientiously and thoroughly observed.

What is the Best Method of Decreasing Waste and Preventing the Accumulation of Individual Prescriptions in the Ward Drug Cabinet?

Many hospitals have a drug formulary and members of the visiting staff are not permitted to prescribe drugs not contained in this book. Where drug cabinets on the hospital wards have been standardized and the containers properly labeled, there need be but little waste in consequence of the prescription of special drugs or other medication. Fluid extracts and tinctures, which are prescribed alone, need not give rise to drug extravagance. It is prescriptions for individual patients, which are compounded in the drug store—capsules or powders, containing two or more ingredients—that produce greatest waste. Writing for twenty-one capsules or powders (which is a common number employed), and the use of but a fraction of this number by the patient for whom these are ordered, gives rise in the course of the year to the loss of many dollars.

Polypharmacy, or the use of many drugs in one prescription, is less frequently practiced nowadays. The administration of two or more drugs singly, instead of being compounded in the drug-store, is more economical and just as efficacious. If several drugs are to be employed in the case of any given patient, it is wise to compound them in capsule or powder form, but it is not necessary to prepare two or three dozen at one time.

To keep ointment in tight glass or metal boxes, which prevents deterioration, and to have these boxes permanently labeled, is a wise move. A periodic survey (that is, monthly or bi-monthly) of ward medicine cabinets, and the return to the pharmacy of unused drugs, is a sensible plan to adopt.

However, the superintendent of the hospital should never be placed in the embarrassing position of failing to supply proper drugs to the ward physicians, and it is likely that, although much improvement can be made in our hospitals, the waste of drugs in the ways outlined above can not be lowered beyond what may be termed an irreducible minimum.

Should the Hospital Insist Upon the Vaccination of All Persons Seeking Admission?

Many hospitals have a rule that requires the vaccination of all patients before they leave the receiving ward. Exceptions in the case of those who are critically ill, or in those suffering with certain diffuse skin diseases are frequently made.

On the other hand, as a general thing particularly during the winter months it is wise to inspect the arms of all those seeking admission, to ascertain whether they have had a good "take" within recent years.

It has been stated by those who are informed on the subject that all persons with a well marked, depressed scar are in reality immune to small-pox.

It is comforting to hospital officials, when a case of small-pox develops in the neighborhood in which the institution is located, to know that should a patient incubating this disease be accidentally received into the hospital, no harm can come to the other patients from this exposure.

Too many people have fixed convictions against vaccination, and while the hospital should not refuse to admit a patient needing immediate institutional attention because this patient had not been recently vaccinated, yet communities can be educated to the need for vaccination, and the hospital should lead in disseminating information concerning this and other public health matters.

It goes without saying that all the hospital's personnel—doctors, nurses and attendants—should be vaccinated against small-pox before they are allowed to come in contact with patients. While the danger of the contraction of this loathsome disease is perhaps remote in most communities, yet the operation of vaccination is so simple, and the outcome usually so certain that no valid arguments exist against the adoption of this method of protecting the health of the hospital's patients and personnel.

What Preventive Medicine Steps Should be Taken to Protect the Health of the Hospital's Nursing Staff?

It is not fair, either to the hospital or to the nurse, for a young woman to be admitted to its school for nurses, who is not physically able to undergo the arduous three years of work and study that will be required of her.

When nurses who are physically below par become ill during their course of study, not only are they made to suffer unnecessarily, but the hospital is put to much expense of both time and effort in treating them. The economic loss incurred through student nurses' illness is a serious problem to many hospitals.

A thorough physical examination of all applicants for admission is the first preventive step to be taken. Prompt rejection of those of poor general physique; those possessing cardiac defects, which are likely to be aggravated by hard work; those of unstable nervous or mental makeup, is plainly indicated in fairness to both parties—the hospital and the applicant.

Those who are accepted with remediable defects, such as hypertrophied tonsils, diseased teeth, or fallen arches should be immediately referred to a staff or other physician for treatment. Vaccination against typhoid and small-pox, Schick testing for susceptibility to diphtheria, and immunization, if protection does not exist, as well as Dick testing for immunity to scarlet fever if the nurse has not had the disease, are all sound preventive medicine procedures. Monthly weighing, and the maintenance of a weight chart of all nurses in the school, often furnish information, which if utilized may prevent tuberculous infection or reveal one otherwise unsuspected. The assignment of nurses who are underweight to a high caloric table in the dining-room, and the enforcement of extra day rest hours, and longer sleeping periods are useful expedients to adopt. Strict enforcement of a rule requiring nurses to report to their superiors the presence of illness of any degree, and the prevention of self-dosage are wise precautionary measures.

Once each year the superintendent of a New York hospital sends one of his assistants on a study tour of the better, new hospitals. It is the duty of this assistant to observe carefully and report conscientiously the many new ideas in use.

The occasional failure of the lighting system while an operation is being performed, as recently occurred in an eastern hospital, lays great stress on the need of supplemental or auxiliary systems in all rooms where major operations are being performed.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

*Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.*

TRAINING THE PATIENT TO BE HIS OWN DIETITIAN

By Helen Nichols, Clinical Dietitian, Cornell University Medical College,
New York

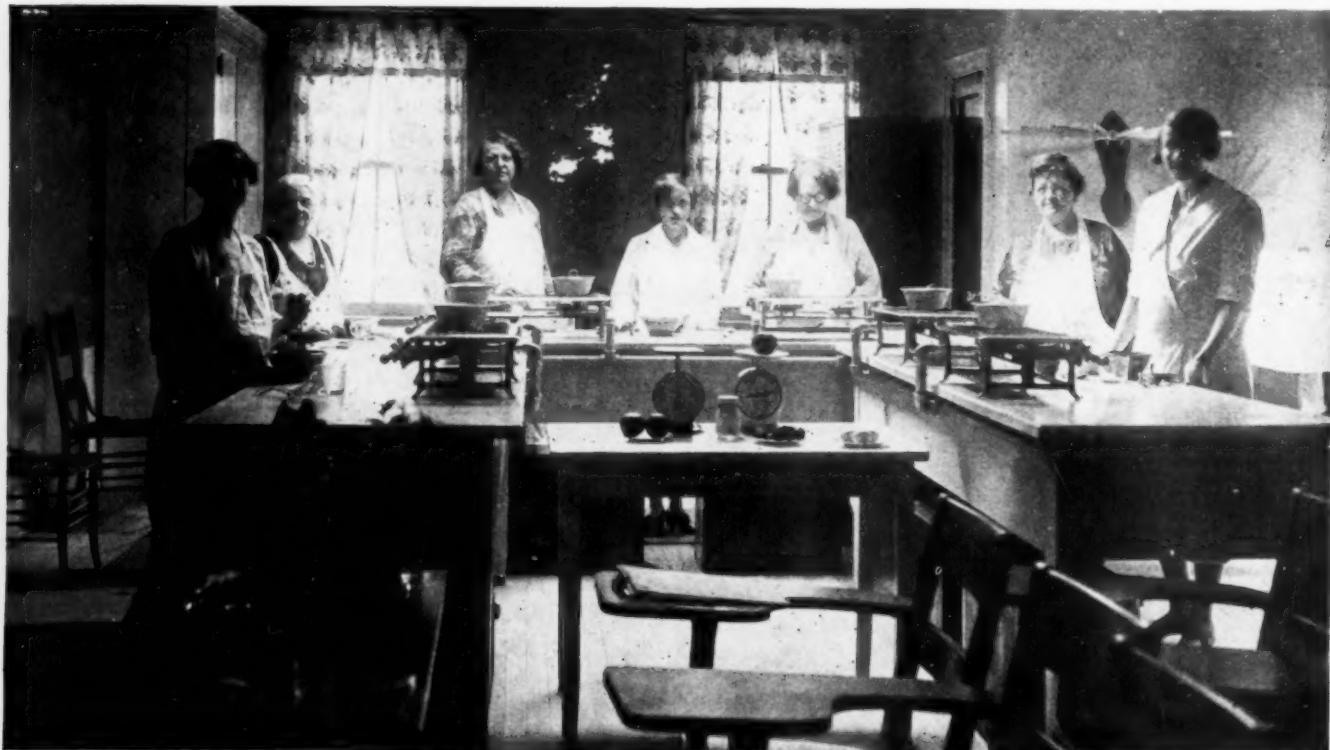
BUT I can't eat that. The doctor says I mustn't." These familiar words are almost always a confession that the patient knows nothing of the principles underlying the treatment of his case, and is following blindly the directions of his physician. Frequently when the doctor prescribes a restricted diet to the patient afflicted with diabetes, nephritis, obesity, hypertension and other conditions in which the dietary factor is important, the sufferer feels that he is being punished. Only by educating the patient regarding the principles governing the selection and preparation of the food on his restricted diet can the most effective cooperation be secured.

The diet courses recently instituted at the Cornell University Medical College Clinic, New York, are based on this principle. When the doctor has diagnosed the case and finds it necessary to prescribe a restricted diet, he

refers the patient to the diet kitchen for instruction. Here the patient enrolls in a six or eight weeks' course with others whose diagnosis is similar. Classes are conducted regularly in diabetes, gout and obesity, and new ones are opened whenever the need arises.

A large, well lighted room serves as the classroom and cooking laboratory. Here each student is assigned to a special table equipped with gas hot plate, oven and a complete set of cooking utensils. There is working space for twelve students at a time and the classes meet each week for a two-hour period.

It is the belief of those in charge of the educational work that the patient progresses most who best understands his own disease. For this reason instruction is not limited to the merely practical phases of dietetics but includes explanations of the pathology and treatment of the abnormal condition. The first forty-five minutes



Diet kitchen of the Cornell University Medical College Clinic.

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of each two-hour period is spent in lecture and discussion.

The diabetic classes have been the most popular. The patients are taught the principles of a normal, balanced diet and then the relation to their individual restricted diet. Glucose tolerance, diet formulae, and food requirement are explained. A discussion of insulin and the causes of diabetes, presented by an experienced physician, paves the way to emphasizing the importance of diet in the treatment of the disease.

The patients are taught food values and learn to plan attractive menus, calculated in strict accordance with their diet formulae. Each week they bring in a calculated menu based on their individual tolerance and requirements. Thus they learn by actual practice what they may safely select for their diet and through these menus come many suggestions of practical value, new to patient and instructor.

During the remainder of the period, which is spent in the preparation of foods, the patients learn to prepare various dishes that conform to the limitations and substitutions required by their diet. They are given printed recipes and copies of all work covered in the class and these they are expected to keep. These copies are helpful as the patient can always, by referring to them, refresh his mind on the subjects covered. Such information as the test for urinary sugar, the care of infections and the method of calculating the grams of carbohydrate, protein and fat in the diet is easily forgotten unless preserved in some such manner. The sheets also offer suggested menus, calculated and balanced.

Natural foods only are used in the preparation of recipes. The patients are warned against using commercial products, of which so many are now advertised, until their use is sanctioned by a physician or dietitian. Sweetening products such as saccharine should be left out as their use is apt to develop a craving for sweet foods, a craving which the patient may later break his diet to satisfy. Such products often make foods unpalatable, especially if



The muffins, orange ice and salad, shown here, are for the obesity class.

heated. The patient can easily learn to like the natural flavor of foods that he formerly was accustomed to have sweetened.

In the education of diabetics the importance of carrying out the rule "Be Cheerful" cannot be overemphasized. Depression and morbidity are early symptoms of diabetes. An attempt is made to put this rule into effect in the clinics and the classes, and the opportunity for personal contacts in the classes is the first step toward success.

Cheerfulness promotes more active circulation and respiration even in the normal person, and for the diabetic, whose body functions are inclined to be sluggish, a happy and optimistic state of mind is of great importance. All who come in contact with the patient can be of great help to him by promoting a cheerful atmosphere.

Patients enrolled in the classes are encouraged to bring up any problems that confront them, and time is then taken for discussion and suggestions. What to put in the diabetic lunch box or picnic basket is a frequent question and special holidays suggest a desire for dinners like those enjoyed in former days. Must the Christmas dinner be like any other, a combination of food elements according to a formula, say C, P, F? The patients are told that the regulated constituents must always be strictly observed, but, in addition, they are taught how to prepare a dinner that has all the color and cheer of the traditional Christmas.

The Christmas dinner for the diabetic can be carried out in a color scheme of red and green. Attractive decorations for the table can be had at little cost. A miniature Christmas tree with its mellow lights lends enchantment to the dinner, or a bowl of holly and mistletoe, and red candles to give light, make an attractive centerpiece. A menu moderate in food value like the following may be served to the average diabetic:

MENU	
Orange Basket Cocktail	Cauliflower Purée
Roast Chicken	Sauté Carrots
Celery	Stuffed Tomato Salad
Whole Wheat Bread and Butter	Olives
	Prune Ice Cream

The orange baskets may be prepared several hours beforehand and placed on ice. Cubes of gelatin dessert, either a variety of flavors, or raspberry alone, decorated with mint leaves, make a most attractive cocktail. The baskets are prepared by cutting the oranges in half and removing the center, then making a slit about one-fourth inch thick on each side, finally bringing each cut slice to the center and tying with a bit of holly and red ribbon.

A purée of vegetable soup may be prepared by using one-half cup of purée and juice of cauliflower and one-half cup of meat broth. Season with salt, pepper, and a teaspoonful of finely chopped parsley. Onion or celery salt may be added. If the diet permits it, the yolk of one egg and a little cream may be added. Beat the yolk slightly, slowly add to it a little of the hot purée, stirring all the while, then stir the mixture and a portion of cream into the soup.

Savory roast chicken holds its place as the ideal *pièce de résistance* for the Christmas dinner. The carrots supplement the fowl very nicely and the absence of potatoes is not noticed. To prepare the carrots slice them lengthwise, boil for fifteen minutes, put in a buttered baking pan and add salt. Mineral oil may be substituted for the butter. Bake, basting often until a golden brown.

Baked Spinach With Carrots

Baked spinach goes especially well with the carrots and fowl. To prepare, place two cups of fresh spinach in an oiled baking dish, pour over it two tablespoonfuls of tomato juice and add salt. Sprinkle a tablespoonful of grated cheese over the top. Bake in a moderate oven.

A stuffed tomato on green lettuce is an attractive salad and carries out the Christmas color scheme. Select round, very firm and even sized tomatoes. Scrape out the inside,

Service That Means Something

By R. E. AMOSS

Secretary and Treasurer, Frank S. Betz Company, Hammond, Ind.



SERVICE is an over-worked word and an under-worked fact. Many people shout "Service" before the sale, but forget it after the contract.

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Some time ago, without any blare of trumpets, we opened a service branch in New York City. Because of what we brought to the hospital in the great metropolitan district, this has been a tremendous success—so much so that we

have had to move it into much larger quarters at Nos. 348-352 West 34th Street. If you are located within sight and sound of Manhattan, we invite you to make this your headquarters for supplies, equipment, and service.

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being careful not to break the tomato. Fill each one with shredded cabbage and cover with mayonnaise. To keep the fat content within limits use mineral oil in the salad dressing:

- 1 egg yolk.
- 1 Cup mineral oil.
- $\frac{1}{2}$ teaspoonful salt.
- $\frac{1}{2}$ teaspoonful mustard.
- 2-4 tablespoonfuls vinegar.

Beat the yolk with an egg beater, add seasoning and then the oil, drop by drop. When the dressing thickens begin adding vinegar, drop by drop, and continue until all ingredients are used.

And now comes the dessert, the course so dear to the hearts of diabetics but the one they must usually forego. Only a small proportion of the cream allowance was used in the morning coffee so that prune parfait may be eaten with impunity.

Prune Parfait

- 1 egg yolk.
- 6 tablespoonfuls 40 per cent cream.
- 2 prunes.

Place beaten egg yolk and three tablespoonfuls of water



A salad of 5 per cent vegetables with mineral oil, shown here, is for the obesity and diabetic class.

in a double boiler. Stir until it begins to thicken; beat until foamy. Fold stiffly beaten cream and finely chopped prunes into mixture. Pour into freezer from which dasher has been removed. Pack with ice and salt and let stand three or four hours.

In the enthusiasm of planning and preparing the Christmas dinner the patients may forget all about the calculation of the grams of carbohydrate, protein and fat. When the foregoing menu is calculated, however, it is found to be suitable for the majority of the class. If it is too high in caloric value for Mrs. Smith it can be readily adapted to her needs. Substitute a consommé with a sprig of parsley for the cauliflower soup. It is just as appealing. If need be, change the salad and use only lettuce.

And so the Christmas lesson is finished with the best of Christmas cheer for all our diabetic friends.

The obesity classes are conducted on a similar plan. A thorough study is made of the diet principles involved in weight reduction. A portion of each period is spent in the preparation of non-fattening foods such as special mayonnaise, desserts, muffins and so on. Special emphasis is placed upon foods that relieve constipation as this frequently accompanies obesity. Agar-agar, washed bran and mineral oil are used to stimulate the lazy colon and may

be employed to advantage as a substitute for food. Tasty congealed desserts and salads are made from agar-agar, having practically no food value. Mineral oil offers many possibilities in the way of salad dressings and as a substitute for fat without increasing the caloric content of the diet.

Most of the patients enrolled in the obesity classes are past the middle age or fifty-year mark. When a person reaches this age physical activity is less, oxidation is slower, and digestive capacity is reduced so that unless one makes a marked reduction in food intake he is apt to overeat. In every case we find overeating to be a contributing cause of obesity even though metabolic disturbances may prove to be the direct cause.

The patients are made to realize that their weight reduction is not only essential to their appearance, but that continued overweight brings many dire consequences in its wake: heart disease, diabetes and other ailments. They soon learn the dangers of reduction without scientific control and medical advice. Gymnastic exercises which the patient may carry out morning and night in the home, are demonstrated.

By arrangement with the Cornell Clinic, diabetic classes are also conducted for the benefit of the patients of the New York Hospital Dispensary. With this group the racial food customs are an important factor.

An attempt is made to adapt the diets to the people as well as to the disease treated. The Jewish people especially have religious customs in regard to their food habits. The process of preparing meats known as kosher is regarded as very important by the Jewish race. "Seething a kid in its mother's milk" was forbidden in ancient times and this is the origin of the present prohibition of cooking or eating meat and milk together. The rule is rigidly followed and necessitates a double set of dishes, utensils and sinks. One can understand why many of the American dishes in which meat or broths are combined with cream sauce are refused by the Jewish people.

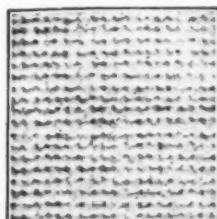
In the diet kitchen we try to adhere to the religious customs of the patients as far as possible. On account of the expense it is impossible to furnish two complete sets of dishes and utensils to each individual but the recipes are planned and the food mixtures combined so that the customs peculiar to each are followed. Once the patients have learned the method in the kitchen they can repeat it in their own homes and thus eat in accordance with their religious rules.

Religious Restriction on Milk

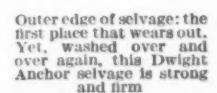
The religious restriction of the use of milk and butter with meat limits at the same time the use of vegetables in the diet. Thus we find the Jewish people not taking of them as freely as they should. This is an important factor in the diabetic or obesity diets in which vegetables are an absolute necessity. Hence the Jewish patients are taught to prepare vegetables combined with meats.

The Italians find it necessary to make an adjustment on arrival in this country. They have been accustomed to a plentiful supply of milk and vegetables which in this country are expensive. In attempting to adjust their diet to their income, they are apt to live almost entirely on starches, bread, macaroni, potatoes and coffee, a bill of fare that quickly leads to dietary diseases.

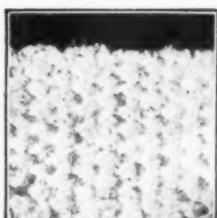
The problem of financing a restricted diet becomes important when the income is small. The fresh vegetables required in a diabetic diet increase the food budget. Patients are taught to select foods with regard to cost, suggestions being made on the purchase of cheaper and bulkier



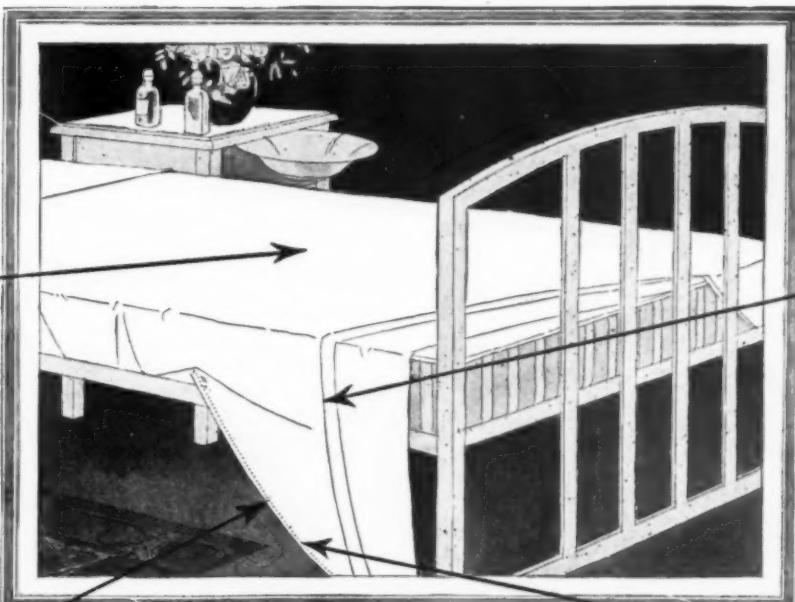
Use, ironing and folding
wear the center fold most.
Yet, on this Dwight
Anchor sheet it shows
no weakening from its
endless washings



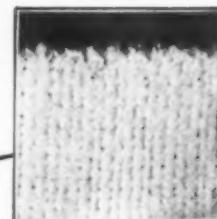
Outer edge of selvage: the
first place that wears out.
Yet, washed over and
over again, this Dwight
Anchor selvage is strong
and firm



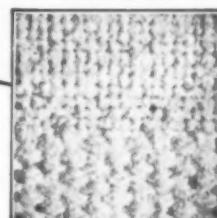
Another weak spot: the
hem edges "go" from con-
stant ironing. But all its
trips through the mangle
left the Dwight Anchor
hem undamaged



Photographs magnified 4 times



Often the inner edge
breaks—the whole selvage
tears off. Note the sound
Dwight Anchor selvage,
after tests that destroyed
other sheets



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tom hems—all the places where sheets wear out first—the Dwight Anchor sheets were strong and firm. No fuzzy edges—no thread breaks—not even breaks in the stitching.

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vegetables. The buying of vegetables out of season is discouraged.

Many different types of people take advantage of the instruction offered in the diet kitchen. An observer would note that on certain days most of the patients entering the classroom are foreigners; on other days they come from the general public of housewives, teachers, clerks and business men and women. As far as possible classes are arranged to afford congenial groups. Many men have enrolled in the classes and show no hesitation in doing all that is expected of them. They gain as much from the course and show as keen an interest in the food lessons as the women do.

Serves as Consultant

In addition to giving the patient training in dietetics the diet department of Cornell Clinic serves in a consulting capacity. Physicians are encouraged to refer their cases of anemia, hypertension, mal-nourishment, and so on, to the department for diet consultation. A member of the medical staff serves as chief and consulting physician of this department. The consultations are given by the dietitian in charge, who advises and instructs the patient with regard to his diet and gives a future appointment so that the case may be followed. An exact duplicate of all instructions given is sent to the attending physician to inform him of the course of treatment.

The only requirement in giving these consultations is that the patient must be referred by a doctor, who sends along the diagnosis of the case and the diet required. Thus the public, also, may take advantage of the diet department. Doctors may refer their private patients to the kitchen for a series of lessons, and New York physicians are taking advantage of this service. Recently a diabetic class with an enrollment of ten had eight of that number referred in this manner.

The classes for diabetes have been of particular aid to the diabetic clinic of Cornell University Medical College. This clinic offers the necessary advantages to the diabetic patient who does not feel financially able to consult frequently with a physician. Every individual afflicted with this disease is entitled to enjoy a long, cheerful and useful life if he follows the principles prescribed by his medical adviser.

Before being admitted to the diabetic clinic all patients are thoroughly examined in the medical department. A complete medical history of the patient serves as a guide to the physician, who decides upon the initial diet. Then the dietitian explains to the patient the kind and quantity of food on the prescribed diet. The initial diet is usually very low in carbohydrate and is continued until the patient is sugar free and the blood sugar shows a decrease. Then the building up of the patient's diet is carried out as his condition warrants.

Dietetic Basis for Treatment

Each time the patient visits the clinic he is seen first by the dietitian who calculates in grams the carbohydrate, protein and fat contained in the diet of the previous day. This information, with urinalysis, blood pressure, temperature and weight gives the physician a basis for his treatment.

Students of the nutrition department of Teachers' College, Columbia University, New York, assist in the clinic and receive credit toward their degrees for this experience.

In almost every instance the patients enrolled in the courses or appearing for consultation have displayed increasing interest in the work. Frequently in completing the course they ask if there is not an advanced course in

which they may continue to learn about correct diet and foods. Members of previous classes often come in to visit and to bring friends who wish to enroll.

STANDARDIZING ON STYLES OF CHINA

While checking over the china and crockery used throughout his institution, one purchasing agent found 124 different styles and patterns. Through consultation with various department heads this number was readily reduced to thirty-five. Upon the acceptance of these styles he made an exhibit of the thirty-five styles by placing samples in a cabinet in his office. All his purchasing is now done from these models. This not only saves his own time and the institutional funds, but reduces the amount of space formerly devoted to the storage of many odd sizes of china and crockery.

SPECIAL COMMISSARY FOR NURSES

A large Eastern hospital has found that its nurses' commissary is so popular that the profits make it possible to break even on the sales. A small stock is kept of such goods as candy, gum, soaps, tooth pastes, manicuring supplies, shoe laces, stockings, stationery, stamps and post cards. In addition the nurses are permitted to order anything they wish through this department, at a saving of from 20 to 50 per cent.

VACUUM BOTTLE FOR BEDSIDE SERVICE

Ten years ago it would have been foolish to predict that 50 per cent of the private homes and many hotels would be using vacuum bottles in their rooms and dining rooms. Today we accept these facts and think nothing of them. We have grown accustomed to such niceties of service. This is perhaps the reason why every room in a large private hospital in Ohio has a vacuum bottle attached to the head of each bed. A special bracket is used so that it is possible for the patient to help himself.

STEEL SHELVES PROVE SUPERIOR

The use of steel furniture has become quite general but for some unaccountable reason its value has not been appreciated in kitchens. Several hospitals, some in the East and others in the West, have found that steel shelves are ideal for use in the pantry and for kitchen storage. They are easier to clean and insects do not thrive on them.

NEWS ITEMS

The Dietary department of the new Billings Memorial Hospital in Chicago is being supervised by Mary Reed.

Mame Porter is taking a leave of absence from Toronto General Hospital, Toronto, Ont., to finish work at Columbia University, New York, for a master's degree.

Lenna Cooper, Battle Creek Sanatorium, Battle Creek, Mich., and Eva Thalman, formerly of Massachusetts General Hospital, Boston, Mass., are also studying at Columbia this semester.

The purchasing agent in a Pennsylvania hospital has this to say about buying at prices that are right. "Courteous and friendly treatment to salesmen almost always results in a saving on purchases. They know the market conditions better than hospital executives can hope to."

December, 1926

THE MODERN HOSPITAL

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The new St. Joseph's Catholic Hospital, Ottumwa, Ia. Crane plumbing materials installed throughout. Architects, E. Brielmaier & Sons Co., Milwaukee, Wis. Plumbing contractor, Ralph Brady, Ottumwa, Ia.

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NURSING AND THE HOSPITAL

*Conducted by CAROLYN E. GRAY, M. A.,
Butler Hall, 402 West 119th Street
New York*

TEACHING NURSING BY THE APPLICATION OF THE CASE STUDY METHOD*

By Effie J. Taylor, Associate Professor and Superintendent of Nurses, Yale School of Nursing,
New Haven Hospital,
New Haven, Conn.

THE title of this paper is not a wholly satisfactory one through which to describe a method of teaching that embodies a new "atmosphere of thought" in relation to nursing. A more comprehensive description of the thought would be given if the title were: "Teaching nursing through a study of the patient as an individual or as a whole."

The new psychology deals with man as an integrated organism and he cannot be understood by studying his parts as entities separated from himself. His physical well-being is expressed through his behavior which is influenced and changed by environmental conditions and mental attitudes. The human being is composite in nature and is made up of a group of systems that work in relation to each other. A well man or woman is therefore one whose system works in harmony toward a desired end and that end interpreted is a healthy, happy human being.

In teaching, methods and means are determined after the purpose and aims have been clearly defined and are bound up in the ultimate objective which is capable of growth. Means may also change. They may be experimental. They may be one or they may be a combination of many methods and devices. In teaching nursing as in teaching everything else we should first determine our aims and an ultimate objective and these in turn will suggest the tools, the sequence and the way in which they will be used.

What Should Education Include?

We are at this time apparently in great confusion as to what the content of nursing education should be. We are discussing curriculum, length of courses and time for practical experience. We are much troubled about relationships, ethical and professional. We are concerned with which group of persons does which particular job. We carry our knowledge about in tight compartments fearful that someone out of caste may acquire an idea that was not intended for him.

The confusion and agitation in our minds is due to

the fact that we have not standardized our objectives and we have not determined our aims. We are evidently trying first to pick out our tools and are endeavoring to use them without a definite purpose. On the contrary, we may have many conflicting objectives which result in a confusion and clashing in the selection of means and devices. I believe the latter is the diagnosis and our real difficulty lies in the fact that we are not at one on the objective of nursing and thus we are confusing the needs of the world, the community and the hospitals with nursing. We are trying to read into nursing a solution for these various needs and therefore we are complicating issues and debating from different angles. Might it not be advantageous to agree to an objective for nursing based on the needs of the individual as a whole and discuss a plan of education for nursing that will prepare students to reach that objective.

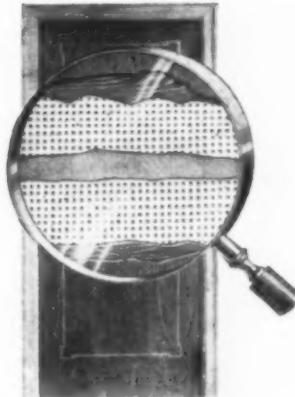
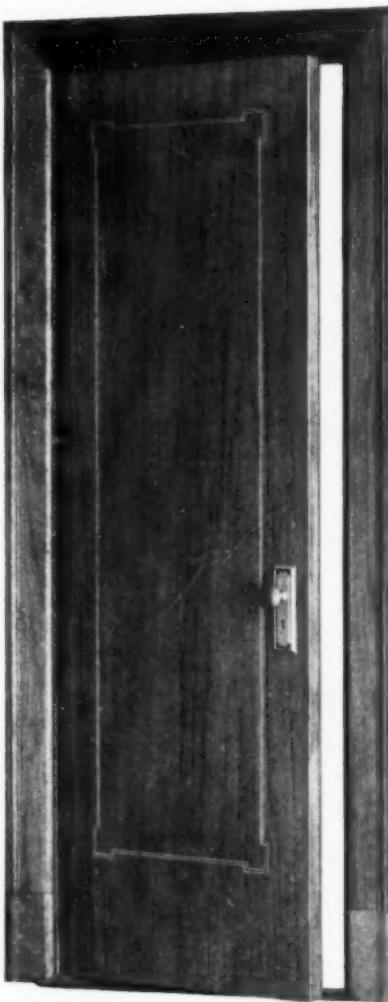
Difficulty One of Economics

When the problem is scientifically analyzed the fundamental difficulty seems to be one of economics, and the debates and arguments are probably the outgrowth of a system that does not provide financially for a nursing service. I believe the whole situation would change if the cost of nursing service were estimated and provided for and if students paid in part at least for their education. Such policies need not radically change the present system by which an adequate nursing service is maintained partly through a school of nursing. The point at issue is really the objective or, better still, how to sort out the main objective where there are many needs.

To discuss a method of teaching nursing and to make some comparisons we will assume as the objectives of nursing education the preparation of the student to (1) become herself a healthy, happy human being and (2) to be a means of helping her patients to attain the same condition of efficiency. Much has been said in recent years about a decline in the spirit of nursing. This has been attributed to the increased personal interest in the student and in her education; in other words, in the getting rather than in the giving. I would rather attribute it to a faulty method of teaching and learning, a method that has not made the patient the center of things, the pivot on which the whole organization swings.

*Read before the nursing section of the American Hospital Association at Atlantic City, N. J., September 30, 1926. Released and publication authorized by the association.

December, 1926



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The hospital should exist primarily for the patient. Not the patient as a case—an appendix, a liver, a heart or a brain—but the patient as a human being who is a member of a family, of a community, with responsibilities, but who must, because of certain conditions, be separated from his natural or habitual environment and be placed in an unusual situation. Nursing is one means used to restore that patient to a healthy, happy efficiency and it should be the business of every person concerned to help him to attain and to keep his 100 per cent of health and happiness. The nurse has a specific service to perform for that patient and her education should prepare her intelligently to work toward this end.

What the Case Study Method Is

With this purpose in view a method of teaching nursing called the case study method has been evolved. The term case work or case study is new in nursing and signifies as in other case work "a driving towards an understanding of the causes of the difficulties and the sources of strength both in the individual himself and in his environment;" or more simply stated a study of the patient as a whole, his family relations and his environment. A study suggests investigation and this requires a systematic method of recording data. A case study, therefore, implies that the student in an organized systematic form seeks information and records it in such a way that it has practical value to herself and others.

As the scientific method of work involves "the collection, recording and classification of facts into series or sequences with the possibility of predicting future facts," the case study method of teaching nursing, in so far as it is analogous, may be termed a scientific method of work. It differs, however, in its ability to predict results or events because of the variability in human beings. Its great value lies in the fact that the patient is the unit about which all thought centers and the gathering of data connected with the patient calls the attention of the student to the patient as a member of the community, and a member of a family with responsibilities to himself and to others which must be taken into account in his present and what may ultimately become his future condition. In contrast to this method, which makes the patient the unit, is the method of centering the attention upon procedures in which the test of nursing lies not so much in the understanding of the patient as in the skill and precision with which one carries out certain technical acts or treatments.

General Criticisms of Nursing

We are all familiar with the criticisms that are constantly made of nursing and of nurses individually. I venture to say that most of the criticisms are due to the system of education, and, further, that most of you who are administrative heads of hospitals or schools of nursing would acquiesce in this statement if you were able to judge of nursing and the preparation of the nurse for her future work, apart from the economic responsibility to your institution. We might not agree on one system but we should all agree that if we or members of our families were ill the last thing in the world we should desire would be a routinized, machinized, mechanical nurse who was proficient in procedures but utterly deficient in an understanding of the human being. When the question is a personal one it is true that an important consideration is efficiency but it must be combined with human understanding, resourcefulness and an ability to think intelligently.

The case study method in contrast to the efficiency

method emphasizes the understanding of the patient and the procedures applied for his recovery, and tends to develop in the student an individual relationship to her patient which makes him not a cardiac or a nephritic or a neurasthenic but a person to whom she and everyone else in the ward has a responsibility in helping him to get well and to keep well. The real nurse should be a health worker, a social worker in its broad sense and a teacher in the institution and in the family. Illness is the result of physical, mental or social maladjustment and nursing implies the care of the whole patient who is a complex human being.

If we think for a moment, I wonder if we will not all agree that in our conflicts the ultimate objective in the education of nurses is lost sight of and the immediate end from which we will not escape or for which we will not or cannot find another solution clouds our vision. We think of a day's work brought to a satisfactory and safe termination as the criterion of our standard, forgetting that in bringing this about through a process of "training," not education, we are making ourselves into efficient machines, crushing initiative and ability to think or apply our knowledge in a practical commonsense way, "except in the way we have learned in the hospital."

Is Hospital Equipment Needed in the Home?

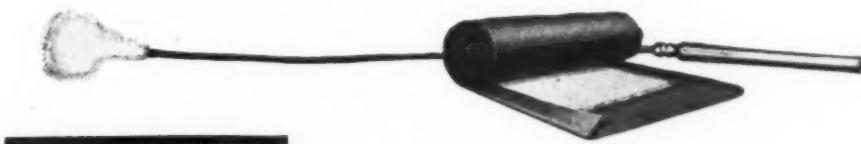
You often hear it said of nurses that they must have a hospital equipment if they are to accomplish anything worthwhile in the home, that they need innumerable people to wait upon them, that they cannot adapt themselves to their patients, that they cannot fit into the family, that they are arbitrary and domineering and seem to know nothing except specific nursing practices which are periodically and methodically administered. These criticisms have some foundation and the fault is not always in the woman but rather in the system of education and the demands of our institutions. In the public health field the average nurse is not acceptable and the reasons already cited are substantially the reasons that are given for her failure.

If the emphasis is placed upon procedures and tasks instead of on the patient to be benefited by the procedure or treatment, if the efficiency with which a task is accomplished and the appearance of the bed or ward is more important than the happiness or comfort of the patient then we must be content with a machine product and the fault is not in the product but in the machinery that turns out the product, and if the spirit of nursing is lacking today it is to some extent at least due to the lack of insight, the demands on time and strength, the hurry, the routine and the number of diffuse exacting tasks that enter into a day's work in our busy hospital wards. This routine leaves no time to live with the patients or to participate in anything that concerns them excepting their admission, beds, diets, temperatures, treatments, charts, and finally their discharge, knowing not from whence they came or to whither they are returning. Perhaps this is an exaggerated picture but too often I fear it is a true picture and patients in a hospital are just patients and procedures are duties and tasks. Is this really education or is it largely experience, drilling and training?

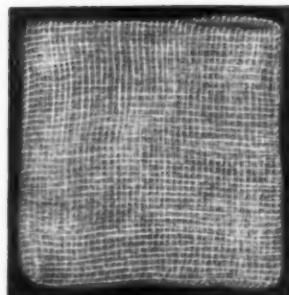
The case study method of teaching nursing or teaching nursing through the study of the individual patient in all his complexities has many advantages for the nurse and patient, and I think I am also safe in saying for the institution, for good nursing implies good care for the patient and good care for the patient is the aim of every good institution. The older method of teaching

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(12)



(13)



(14)

(Continued from page 127, November)

12. RED CROSS COTTON

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has possibly some advantages to the student but more to the institution and is well termed the efficiency method. Where it is employed wholly, however, it is for expediency, for economy and for results shown in the general appearance in the wards or to facilitate the work of other groups.

There is no doubt that if one person is assigned to take all the temperatures, another to give all the medicines, another to give all the treatments and still another to do all the charting or to serve all the diets, she will become an expert in that particular type of work, but too often because of that acquired expertness and skill students are kept for weeks on specific duties or in specific services without regard to whether or not they will be deprived of some other duty or service to which they are entitled and which will be an equally important or more important experience.

The advantage to the student is largely measured in skill and deftness in execution. It is easily conceived, however, that if combined with the case study method or in addition to the case study method, certain procedures are carried out in large numbers they may be made the basis of comparison, and the differences or similarities in reactions to treatments might provide an opportunity to acquire a wide knowledge of disease through the changes that occur in different individuals. If this system were developed upon scientific principles, and the gathering of data, the recording of findings, and the comparison of conditions were included in the plan of education, the two systems combined would no doubt provide an ideally constructive educational nursing program. The combination of different methods, each occupying a logical place in a purposeful program of education, is ideal and particularly is it so in nursing where human situations are so variable, for a nurse should never become a slave to one set of ideas but should be versatile, adaptable and resourceful.

One of the most important assets for a nurse is a point of view and a sympathetic understanding of the many relationships bound up in life, and it is important to realize that many factors contribute to the happiness and welfare of a human being. To teach nursing by the case study method supervisors, head nurses, social workers, nutrition workers, physicians and all concerned with the care of the patients must work in cooperation. Patients should be assigned to students for care and study by the head nurse in conference with the supervisor. Under supervision the responsibility for the entire care of the patient should be given to the student insofar as she is at the time prepared to assume it, and by a system of relief assignments the patients should be cared for by other groups of nurses while the student responsible

for the care of the patient is taking her time off duty.

The following quotation from an article written by a student nurse for her college alumnae quarterly on the system practiced in Yale University School of Nursing, will give the viewpoint of the student rather than that of the administrator or teacher:

"The aim of the ward work is to make the student responsible for the entire care of her patients. Instead of giving her certain duties that must be performed for all patients in the ward so that she has in mind only a picture of a cross section of the whole ward, she is given certain patients as her own, and it is her duty to be responsible for their entire nursing care. Before beginning her work she must have read and understood her patients' medical records, so that her care of them will be intelligent. If orders have been given that she is not yet trained to carry out, it is her responsibility to see that others carry out these orders. In this way she obtains a comprehensive understanding of the pathological conditions involved and the steps necessary for their treatment, and can intelligently follow the progress of her patients day by day. Also she is taught that it is not enough to care for her patients' physical well-being while in the hospital, but it is constantly emphasized that the nurse must think of them as members of families and communities and as resuming normal life again outside. The school of nursing is hoping to inculcate in the minds of all its students a sense of responsibility for the welfare of their patients and it is for this reason that they are trained to share in the social service aspect of the problems, in order that they can feel responsible for the entire care of the patient."

Through the case study method of learning, nursing can never be to the student a set of routine procedures. Attitudes of mind, ideals and standards are fundamental principles and must be taught coordinately with skill and technique. The patient is the center of activity and procedures are important only insofar as they contribute to his welfare. To discriminate wisely and intelligently the student must have knowledge and practice and must know what things belong together and what things should be kept apart. Whether the method under discussion will satisfy all needs we cannot tell. Its great value lies in its possibilities for expansion and growth, for it is not fixed or arbitrary.

In speaking of the League of Nations, someone said: "The League of Nations was not sent by the Deity into the Paris conference halls a perfect mechanism fashioned to endure forever without changes, but is an experiment and the embodiment of an ideal that will be improved by experience." Thus it is with the case study method as applied to the teaching of nursing.

From the Standpoint of the Municipal Hospital

By Marian E. Rottman, Director of the Nursing Service and Principal of the Schools of Nursing,
Bellevue and Allied Hospitals,
New York

THE objectives of nursing education are recognized by the municipal hospital as identical with those of either the private hospital nursing school or that institution of higher nursing education, the university school.

The student nurse must aim to be a "healthy, happy human being and a means of helping her patients to attain the same efficiency," and it is the duty of the

hospital and school of nursing to supply the means by which this objective may be accomplished.

The means that must be supplied are favorable working conditions as regards physical environment, hours of duty, clinical material, instruction and supervision. Today most schools worthy of the name are supplying all these means in reasonable amount, except the last—supervision.

Just as the case study is the center of the nurse edu-

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eating activity in the Yale School of Nursing, so should it be in all schools of nursing. The fact that any nursing school has not the favorable and almost ideal conditions of the Yale school is no excuse for not utilizing the facilities at hand, striving for better facilities and laying a plan of procedure.

It is true that as a rule there are more patients per nurse in municipal than in other hospitals, but it is equally true that the wealth of clinical material and opportunity for education is many times multiplied.

Let us review the case study as used at Bellevue Hospital, New York, to determine whether or not it contributes to the better nursing care of the patient, to more intelligent information and knowledge for the student and to the general efficiency of the hospital service.

The form used at Bellevue has undergone many changes in the last three years in an effort to simplify and clarify the material we deem necessary for the study. I shall describe the form and the method used to make the study at the same time.

The object is to make a scientific study of a number of cases to determine what is the best nursing care for a particular disease, and the ability to make adaptations to various individualities.

In order that the student may become acquainted with the patient as an individual it is necessary to obtain his social and health history, as well as his medical history. To obtain this we provide an outline of the items of information necessary for the study.

First we state the source of the information and from whom it was obtained, whether from the patient, his family or friends; his age, nationality, the number of children in the family and by whom he was brought to the hospital. We must then obtain information regarding his standard of living, his neighborhood, his home, what is the sanitation, heating, lighting, water supply and toilets; what is the income and what the rent. Is there a family problem due to illness? Why was the patient brought to the hospital? Does the mother go out to work? Are others ill in the family? What social agencies are they known to? In obtaining this information the student is taught the value of tact. We would rather the student did not get the history if it cannot be obtained without hurting the feelings of the patient or those interested in him.

Health History Needed

Next the health history must be obtained. What is the patient's weight, his height, compared with the normal? What is his daily regime? what are his habits of play or work, his special interests and exercise? What are his habits of elimination and cleanliness? How many baths is he accustomed to? What care does he give his teeth, hair and nails? What about his diet—how many meals daily, when and where eaten? What foods does he like best, what are those he does not like? Does he drink water, tea, coffee, cocoa, soda? What are his habits of sleep and rest? How many sleep in the same room and the same bed? Are the windows open or shut? At what hours does he go to bed and get up? Is there regularity in his regime? What about bad habits? Are there night terrors, bed wetting, nail biting, thumb sucking, sleep walking, tics, etc.? What is his social behavior?

In obtaining his medical history the last is important, especially those points bearing on the present illness from the onset, the duration, complications and sequelae. The obtaining of this history is bound to interest the student in the patient. With this background of information the student's care will be more intelligent,

because she will understand the reason for certain treatments and she will know what results to expect. Our experience has been, especially on the pediatric service, that this questioning by the students is well received by the parents and much better cooperation is obtained from them in caring for the child.

The next point in the study is the observation of symptoms, whether subjective or objective—what does the x-ray reveal and what are the laboratory findings? What is the prognosis for the particular case and for the disease in general? The fifth heading refers to the reference read. The author, the pages, the points in regard to symptoms, treatment, medication, etc., that are recorded in the book and not exemplified in this particular case should be noted. This makes the student familiar with the atypical as well as the typical case.

In successive treatments, medication, nursing care and diet are studied. Much detail is required here, stating why each is given, what result is expected and what result obtained. With these four headings much supervision is required. There is a tendency to generalize in statements and especially in nursing care. Good nursing care is detailed and unless we can analyse it item by item the finer points are apt to be overlooked or slighted. The doctor's orders must be studied. The treatments carried out by the doctor and those carried out by the nurse, the x-ray treatment, occupational therapy and physiotherapy must all be emphasized in regard to results obtained. In regard to diet, it is important that what the patient is allowed be stated, also what he eats and what he leaves and the devices used to encourage him to take more.

Progress of Patient

Next we observe the progress the patient is making or if he is not improving what the indications of his regress are.

In the next item we try the student out in her judgment by asking her to describe a desirable environment into which she would put her patient if possible.

The fact that every student in the school is a health teacher is impressed upon each one and in every study the health habits taught are stated. These may be habits at the table, in sleeping hours, in regular eating and regular elimination and habits of general cleanliness and the use of the tooth brush.

After we have restored our patients to health and have discharged them from the hospital we try to follow them into their homes. Here our social service department plays its part, but more and more we find the students inquiring of the progress of their patients and in the children's department many students are following their little patients into their homes, instructing and helping the mother as to the treatments and diets. They are advised to return to the clinic if necessary or to be readmitted to the hospital. Many students interest the social service worker in their particular cases and urge convalescent care in the country. Without this personal interest of each nurse in her individual patient many might be overlooked in a hospital as large as Bellevue and where all are dependent in a greater or less degree.

The last item is the student's criticism of her own work. This is the student's own check upon her work. Did she find ways of improving the care of her patient after the first day? Did she give her patient the best care she knew how to give? If not, what was lacking. In a municipal hospital where time is at a premium when the wards are full to overflowing, did the student discriminate and do the most important things for her pa-

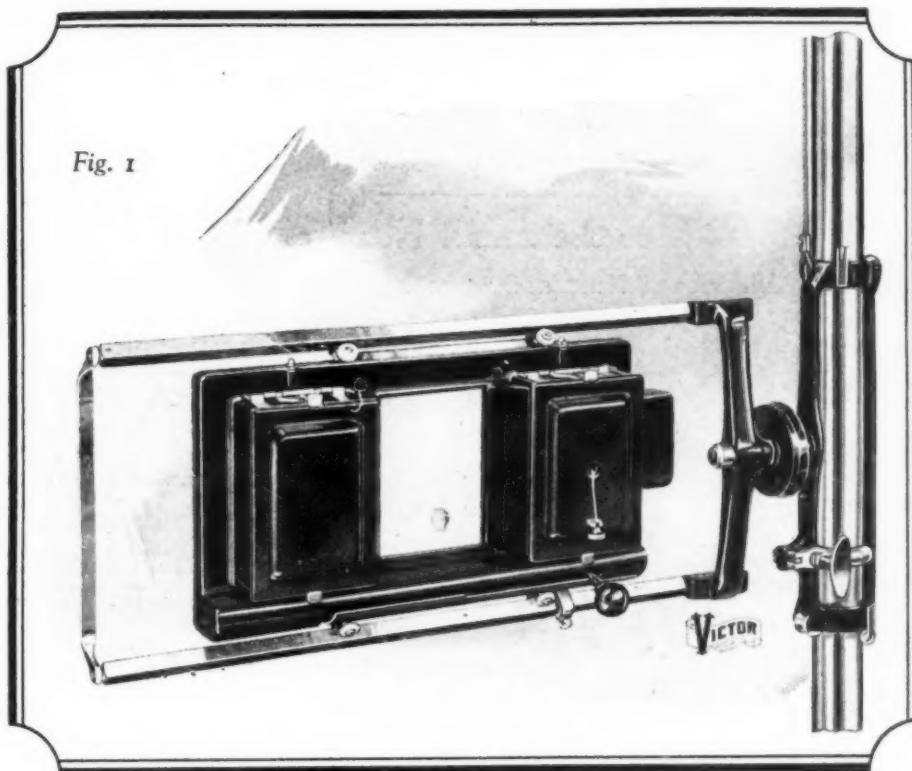


Fig. 1

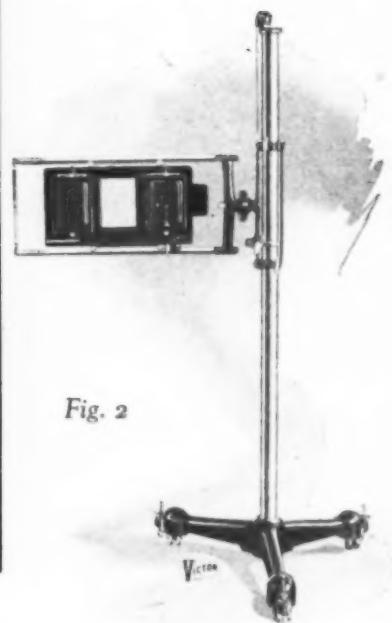


Fig. 2

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Referring to Figure 1, the fluoroscopic screen carrier has mounted on it also two magazines, one on each side of the screen. The magazine at the right of the fluoroscopic screen holds six 5 x 7 cassettes with films and intensifying screens. During a fluoroscopic examination the operator may at any moment desire a radiograph of a certain pathology observed. He then needs only to grasp the knob at the lower right, and shift it over to the first notch to the left (which brings one of the cassettes into position behind the fluoroscopic screen), steps on the button of the floor switch to energize the tube for the radiographic exposure, then shifts the knob over to the extreme left in order to deposit the cassette in the magazine on the left of the fluoroscopic screen. The knob is now shifted back to its original position on the right, and the fluoroscopic examination is re-

sumed until observation calls for another radiographic exposure, when the above procedure is repeated.

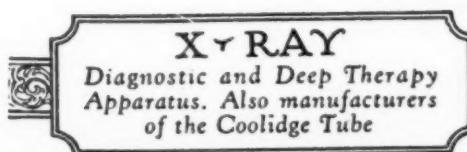
This is accomplished without loss of time, and without the operator moving away from his position in front of the fluoroscopic screen. A two-button floor switch gives him selection between fluoroscopic and radiographic currents. At his arm's reach is also a small control stand (auxiliary to the regular auto-transformer control on the X-Ray machine) thru which he may vary the penetration as required during fluoroscopic examination, also control the Coolidge filament circuit to vary the fluoroscopic milliamperage.

Figure 2 shows the Unit proper mounted on floor stand. The complete rotation of the horizontal arm by means of its swivel attachment to the vertical column, permits of any angular position required in either radiography or fluoroscopy. Vertical adjustment is quickly and conveniently made thru a counterweight suspended by wire cable in the vertical tube column, and operating over the swivel pulley at the top. Note the conspicuous absence of electrical parts or wires to be avoided by patient and operator.

Its range of usefulness. Practically every specialized laboratory will realize its advantages in almost every phase of fluoroscopic diagnosis. Consider its value in the radiography of nervous children especially, where locating the area and positioning of the part are difficult before the radiograph is made. The fluoroscopic screen may be here resorted to, then the radiograph made instantly—no need of moving the patient over to another radiographic unit. In fracture cases, too, it suggests itself in many ways. Finally, in serial radiography of the stomach it serves ideally, answering every possible requirement in the most practical and efficient way.

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tient and does she realize there were other things that might have been done had there been time?

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Together these have made for a better nursing service, more intelligent care on the part of the nurse and a greater interest in our patients.

From the viewpoint of the municipal hospital the results of case studies are far-reaching although difficult at first to establish.

From the Standpoint of the Small Hospital

By Margaret Ashmun, R.N., Director of Nurses, Orange Memorial Hospital, Orange, N. J.

IN THE small hospital our objective is to nurse with the heart, the head, and the hands, and to this end we find the case method of study particularly well adapted. The economic question does enter into the picture where the hospital is run on budget, and the well trained supervisors for this work must be a gradual addition.

We have found that by having the students prepare one or two thoroughly worked cases a term—such as, the bacteriology and pathology of the disease with laboratory findings; anatomy and physiology of the parts affected; medications; treatments and diet; progress of a patient as well as a careful study of the patient as a member of a family and community, present and future—that the students have an example to apply to all their patients.

Each student has her own patients and is responsible for their entire care under supervision. She is quizzed orally every week, on the points deemed important under the case method, and we hope soon to follow the suggestions for weekly written case studies. These quizzes embrace a short history of illness with diagnosis, treatments, medications and results, progress of the patient in the hospital and information relating to the home conditions as obtainable from the patient. They are conducted by my assistants or myself without warning to the student, during our rounds, and we have found the student well versed about her patients in most cases, and keen not to have to admit ignorance on any question asked. In fact we often have the tables turned and ourselves quizzed.

The chief difficulty in establishing the ideal method of case study lies in the lack of trained supervisors for this work and in the fact that in a small hospital patients come from such distances that it is not yet possible to give the students ample time, or arrange transportation, for them to visit many of the homes.

Certainly, I am agreed that the mechanical, machinized nurse is undesirable and that if, as Miss Taylor says, she is the product of our teaching, then it is our duty to put forward strenuously any new ideas that will obliterate her. Nevertheless, I do feel that procedure must be stressed, whether it be a bed without wrinkles or a catheterization with perfect technique, for the welfare and happiness of the patient, in my estimation, depend largely upon the skill with which procedure is carried out.

It is true we hear that the spirit of nursing is not what it used to be, but do you not think the chief complainants are the older nurses, the students of thirty years ago, and some older physicians? The women who took up nursing in those days no doubt went into it older in years than our present students and with no idea except service. We cannot alter the present generation, and most of the small hospital students are just eighteen, gathered in from the high schools by talks on nursing, ideas of service, yes, but also ideas of education and a profession and a means of livelihood, some few, no doubt, as an excuse to leave home and try something new.

Surely, then, it is up to us—directors and educators—

to put forth our objective in the ablest manner yet evolved and to teach through environment, scientific knowledge and technique, or, in other words, to teach efficiency of the heart, of the head, and of the hands, always stressing efficiency of the heart. Then the spirit of nursing will not die.

A FOUNDATION IN NURSING EDUCATION ESTABLISHED AT UNIVERSITY OF CALIFORNIA

An important development in nursing education was consummated when the California Legislature of 1925 passed a bill which created a foundation in nursing education in the University of California. The impetus for this action was given by the nurses of California in meeting the desire of the state board of control for the disposal of a surplus fund accumulated from registration fees received by the Bureau of Registration of Nurses. This fund had accumulated during a period of two years since it had been "frozen" by a decision of the Supreme Court in 1923. The directors of the California nursing organization decided that this surplus amount should be used to establish a chair of nursing education in the University of California, Berkeley, Cal.

The technicalities involved in the transfer of funds from one state department to another have finally been overcome and the next step in the establishment of the new Foundation in nursing education at the University of California has been accomplished. On October 13, the regents of the university, on recommendation of the president, appointed Mary May Pickering, R.N., as assistant professor of nursing education. Miss Pickering will assume her duties on January 1, 1927. In order to take up this new work, Miss Pickering leaves her position at the University of California Training School for Nurses, of which she has been the director since January, 1922.

This chair of nursing education will be placed within the department of hygiene. While the department of hygiene is responsible for the administration of the chair, other departments will contribute in no small measure to the needs of this young foundation. There will be courses in teaching and administration in schools of nursing, accompanied by correlated courses in history of education, psychology, principles of teaching and preventive medicine.

A committee on nursing education has been appointed by the president of the university to act in an advisory capacity. This committee consists of the deans of the medical school, the school of education and the college of letters and science; the chairman of the department of hygiene; the assistant professor of public health nursing; the assistant professor of nursing education; the presidents of the California nursing organizations and the director of the bureau of registration of nurses. The dean of women in chairman. This committee will outline the general policies and curriculum.



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*Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York*

HOW FOLLOW-UP AIDS IN MAINTAINING AN EFFECTIVE SYPHILIS CLINIC*

A Report Based on a Two Years' Experiment at the Syphilis Clinic of the Brooklyn Hospital, Brooklyn, N. Y.

WHAT is a follow-up system and what is its value in making clinic service effective? Does systematic follow-up help materially in keeping patients under treatment until they are cured? How much does a good follow-up system cost?

The answers to these questions are particularly important in considering the methods employed in a syphilis clinic because of the gravity of the disease, its communicability in certain stages and its important relations to public health. Since treatment must extend usually over a long period and is expensive and not agreeable, patients are likely to discontinue too soon. Therefore, any plan that will aid in the control of cases is worth consideration.

For these reasons the venereal disease section of the Associated Out-Patient Clinics of New York City and the authorities of the Brooklyn Hospital, Brooklyn, N. Y., cooperated in a two-years' experiment in the syphilis clinic of the Brooklyn Hospital out-patient department, to develop the principles, methods and value of a follow-up system in a syphilis clinic.

Two Years of Treatment

The syphilis clinic at that time held four sessions a week, two in the morning and two in the evening, men on one day and women and children on another. The staff consisted of a chief of division and two groups of workers, one of which attended the sessions for men and the other sessions for women and children. The chief of the division was permanently the consultant at all sessions. It was his duty to interview new patients after the history and examination on admission had been made, in order to see that the patient understood his problem, the why and wherefore of treatment. He also interviewed all revisits. It was adopted as the underlying principle that no patient should have less than two years of treatment.

This clinic had had a follow-up system for a number of years. During the period covered by this report the system was somewhat developed and was critically studied.

The results of the work in this clinic may be analyzed thus:

No method of sending notes and letters or making home visits urging patients to persist in treatment can be successful unless this is supported by a clinic, properly managed, to supply efficient treatment, to care for the patients promptly, to create in the minds of the patients through their contact with the clinic personnel an understanding of the need for thorough prolonged treatment, and, by the proper professional and human attitude of the staff, to demonstrate that the problems arising in each case are taken into consideration.

Follow-up Procedure

As a supplement to this fundamental work done while the patient is in the clinic, the follow-up efforts in the study consisted of sending one note and two letters and the making of home visits. Of the 1,028 patients handled throughout the period of the study, 40 to 47 per cent of all active cases required some follow-up effort. Such effort was made after two unexcused absences of the patient from the clinic. Follow-up by mail produced a noteworthy response and was successful in causing patients to return to the clinic in a sufficient number of cases to justify fully the small cost of such procedure. This cost amounted to only eleven cents annually per patient.

In addition to the mailed notices home visits were made. The number necessary was very small, however, only about 2 per cent of the total number of efforts made. As it was found unsatisfactory to attempt home visits upon men, a fourth notice was substituted for them. Home visits to women and children resulted in the return of 29 per cent of those upon whom they were made. This percentage was greater than in the case of the man who received the fourth mailed notice, to which 16 per cent responded.

Although wrong addresses have been sometimes mentioned as serious detriments to the functioning of a follow-up system, in this study they were responsible for failure in only 5 per cent of the total number of follow-up efforts by mail in the case of men and in only 2 per cent in the case of women and children.

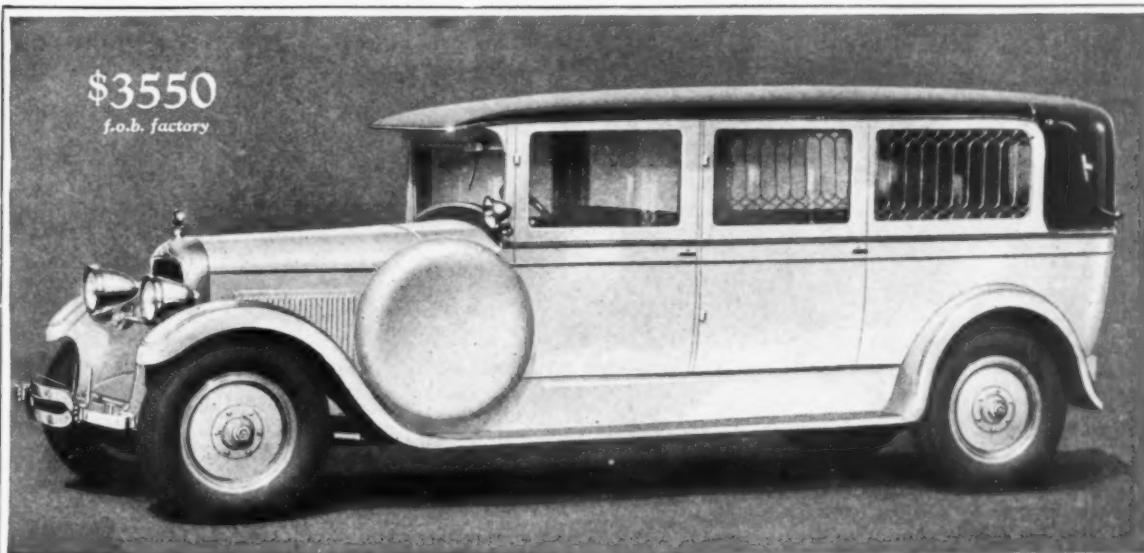
Since the purpose of the study was to determine as accurately as possible the value of follow-up in keeping the patients admitted to a clinic under proper control, no

*Editorial summary of a pamphlet entitled "Follow-Up System in the Syphilis Clinic," published by the Associated Out-Patient Clinics, 244 Madison Avenue, New York, September, 1926.

December, 1926

THE MODERN HOSPITAL

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intensive social work other than that called for for this purpose was attempted.

The social worker was considered an associate of the chief of clinic, her work being distinct from, although closely associated with and complementary to, the medical aspect of the case. Her phase of the work was carried on as follows:

1. Initial contact with the patient on admission to clinic. At this time she obtained the necessary identification items for the history sheet. During part of the study, she also took a short social history as a routine, in order to obtain information to help make plans for the widening of the social work when it would be desirable to do so.
2. Complete social interview on cases presenting an urgent social problem.
3. Home visits on women and children who failed to respond to three notes.

4. Home visits with consent of patient on cases presenting fundamental social problems. In this group were not a few instances in which a visit was requested by the patient for the purpose of aid in explaining the situation to the family.

The kinds of work required to maintain the follow-up system during the experiment and the time necessary were analyzed. The chief of the section spent about half an hour a week in selecting cases from the active file to receive notes. The rest of the work: Writing and mailing the notes, checking those sent out and those returned on the history envelopes and closing the histories for the latter, was done by the clerk and occupied about five hours of her time weekly. Thus, it is evident that the detailed mechanical work is only an incidental feature in the follow-up system and its expense. The really important element is the general management of the clinic, which requires not only interested attention by the physician and adequate clerical service, but close co-operation on the part of the entire clinic personnel.

The analysis of the experiment in the Brooklyn Hospital syphilis clinic indicates that, given a completely manned clinic, adequate care and instruction of the patient at his first visit, sufficient clinic assistance and a carefully planned system of case control, follow-up will be effective.

Outstanding Results of Work

Some of the outstanding findings indicative of the efficacy of the service were:

1. Of the 1,028 cases treated during the first year of the study, 1922-1923, 72 per cent were controlled satisfactorily.
2. Of the same cases, 34 per cent were still active at the end of the ensuing year, 1924, with an average attendance of forty-seven visits to the clinic.
3. The communicability of the patients, at the end of the year was reduced from 26 to 5 per cent.
4. More than half of the total number of patients required no work outside of what was done in the clinic itself to bring them back for treatment.
5. Each of the cases that was followed up required an average of 2.4 efforts. A few patients required a large number of efforts, but not many needed more than four or five.
6. The total number of 2,402 mailed notices produced a return of 843, or 35 per cent of the patients to the clinic. The return to the first notice was 40 per cent; to the second, 31 per cent and to the third, 28 per cent. Those patients kept under treatment for the minimum period demanded by the plan of treatment, two years, made practically the full number of visits required.

Of those cases closed before the full amount of treatment had been received, many were closed for adequate reasons (that is, assigned to other medical care; treatment not needed; died or left town). From this viewpoint, of the patients admitted during the period of the study nearly 75 per cent were kept under satisfactory control.

Another special study was made of the clinic work during the year 1924. In the average number of visits per patient, this year surpassed both previous years: 1922—10 visits per patient; 1923—11 visits; 1924—12 visits. This improvement occurred in all groups and was, of course, reflected in a lessened number of closed cases.

Conclusions Reached by Committee

As a result of the two years' work at Brooklyn Hospital the joint committee representing the two participating organizations reached the following conclusions:

1. The efficiency of a clinic in keeping its patients under treatment depends primarily on its personnel. If the physicians are skilled and considerate and are provided with necessary trained assistants; if the patients are individualized, and if the clinic has sufficient equipment and other facilities to do adequate medical work, results will be constant and immediate. Service to the patient is the test which the patient more or less instinctively applies. Patients react as human beings to service rendered and to sincere efforts on their behalf.
2. Assuming satisfactory work done in the clinic, particularly at the first visit, the majority of patients require no additional follow-up work. For a certain proportion of patients, however, follow-up by mail is needed and gives good results.
3. Wrong addresses present slight difficulty if care is taken in recording addresses and keeping track of changes. False addresses are an extremely minor problem.
4. Home visits are of distinct value in connection with the treatment of patients, and with follow-up in a certain but not very large proportion of cases.
5. Home visits for men are usually impractical, particularly when men are living in lodgings. In general, men, for occupational and other reasons, are more difficult to hold under treatment than women.
6. In the follow-up by mail, the form of notice seems to be of little importance.
7. Promptness in sending the letter or note is important.
8. The amount of time and expense entailed in connection with follow-up by mail is small in view of the results achieved.

Recommendations

The committee, after reviewing the conclusions given above, made the following recommendations concerning a desirable standard for every clinic treating syphilis:

- I. Provision in the clinic of the services of a properly qualified person, possessing the training of a nurse and of a social worker.
- II. That all patients who are neither discharged nor transferred shall, at each visit, be assigned a definite date for return and be instructed in the importance of continued treatment.
- III. That records of the date of the expected return visits be maintained.
- IV. That delinquents be notified by letter and, when indicated, by home visits.
- V. That the health department be notified of all delinquent cases where disease is considered in a communicable stage.



Fischer
CHICAGO, ILL.
3 1/4 M

The New FISCHER Intermediate Model "V"

An Efficient,
Powerful Diathermy Outfit

- - Yet Economical of Space
and in Cost

THIS newest product of Fischer skill is the ideal Diathermy Outfit for the hospital Physiotherapy Department. Embodies all the many improvements the Fischer engineers have made in Diathermy apparatus. Perfected (Kolischer) spark gap, absolutely smooth in action. Auto-control, for even regulation of power. Four voltage outlets, fully insulated, set at an angle so cords cannot slip out. Extra large meter. Beautiful cabinet.

To those interested, we shall be glad to send our booklet No. 430 A and our special proposition to hospitals

H·G·Fischer & Company, Inc.
Physiotherapy Headquarters
2333-43 Wabansia Avenue
Chicago, Illinois

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and
Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

IS THE VERTICAL TYPE LAUNDRY PRACTICABLE FOR THE LARGE HOSPITAL?

OF interest to the larger hospitals of the country is the vertical four-story laundry of one of Chicago's largest hotels. The building, which is located several blocks from the hotel proper, is 115 by 175 feet and is built of concrete and brick and especially designed for laundry purposes.

As the power and mechanical equipment are similar to that used in hospital laundries, a detailed description of these features will not be given, but in order to follow

out the different laundry processes, the various steps through which the clothing passes will be described.

The work received by the hotel laundry is divided into two classes, namely, flat work and guest work. The greater portion of the work received is, naturally, of the former class. As shown in the accompanying diagram, Figure 2, on the fourth floor the goods are received, sorted and placed in the self-weighing hoppers for delivery to the four 48 by 126-inch washers that are stationed on third floor.

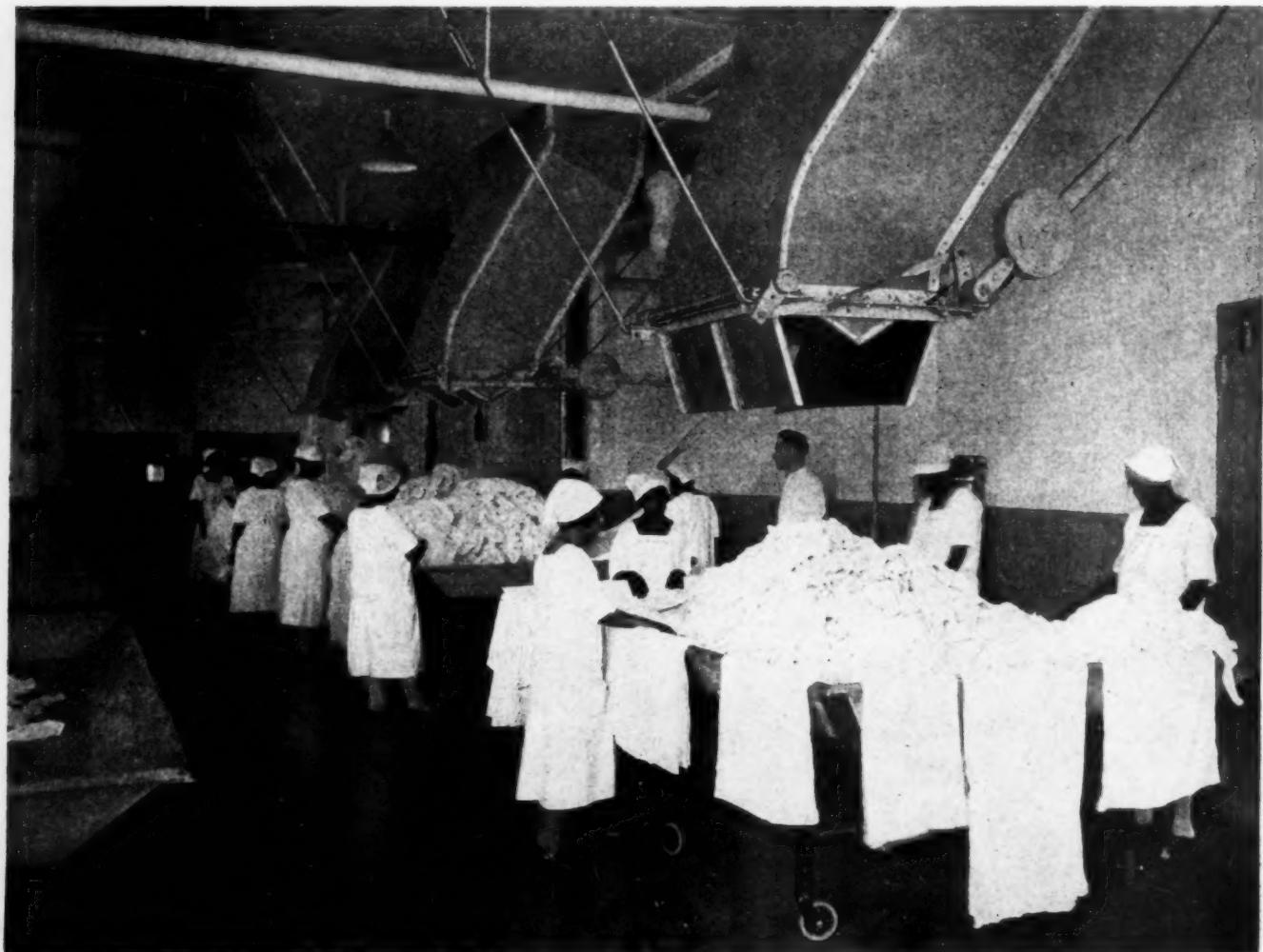


Figure 1. A view of the room where the clothes are received from the chute and placed on the shake-out tables.

Laundry convenience in the hospital

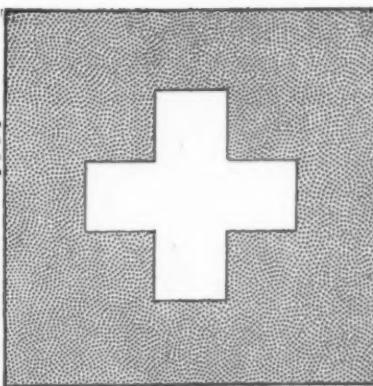
AMONG the factors that contribute to the convenience and efficiency of the hospital laundry are rapid drying of clothes, quick ironing in modern gas-heated ironing machines and general cleanliness and freedom from dirt.

These conveniences depend directly on the availability of a satisfactory gas service. For hospitals not located near a supply of city gas, Pyrofax makes these laundry conveniences possible.

Pyrofax gas resembles natural gas and is shipped to the hospital in steel cylinders. It is non-toxic and burns with a clean, hot flame free from soot or odor. It can be used on any standard gas appliance—ranges, hot plates, Bunsen burners, and laundry ironers.

The Pyrofax installation consists of a substantial enameled steel cabinet which houses the cylinders and fittings. It is placed outside the building and the gas is piped from it through ordinary gas pipe to the stoves, burners and other appliances. It is listed as standard by the National Board of Fire Underwriters.

Any further details will be promptly furnished on request. May we not send you our circular and booklet describing Pyrofax?



CARBIDE AND CARBON
CHEMICALS CORPORATION
General Offices: Carbide and Carbon Bldg.
30 East 42d Street, New York

Pyrofax
TRADE MARK



REAL ESTATE LOANS

TO THE BORROWER:

Statistics covering building construction throughout the United States in the last few years show conclusively that CHURCHES, SCHOOLS, CONVENTS, HOSPITALS, and all classes of buildings intended for religious purposes, continue to keep abreast of the times in the erection of new buildings.

Recognizing a sound, economic law, those in charge of religious houses are financing the construction of these buildings or refunding existing indebtedness by a first mortgage loan extending over a period of years. In this manner the benefits and responsibilities are shared by the present and future generation and the burden is not found irksome by either.

For more than twenty-seven years the Mercantile Trust Company of St. Louis, Missouri, has made a specialty of financing churches and religious institutions, not only in its home city but in practically every section of the United States. Millions of dollars furnished by it have made possible the erection of scores of institutional buildings throughout the land. Through these years of experience in handling loans of this character we are in a position to give valuable advice and assistance in such transactions.

Correspondence and interviews invited.

TO THE INVESTOR:

Operating on a very extensive scale, with a broad field from which to select our loans, we are enabled to offer at all times, to investors, not only the maximum of service but a class of securities that measure up to the highest standard of safety and desirability.

Complete detail circulars of issues we now offer mailed on request. Purchases of notes made by non-residents filled with the same dispatch as locally. Delivery made at our own risk. Reservations may be made for immediate delivery or delivery within thirty days.

*Address all inquiries or orders for Real Estate Notes to
REAL ESTATE LOAN DEPARTMENT*

Mercantile Trust Company

 Member Federal Reserve System
 Capital & Surplus Ten Million Dollars
 EIGHTH AND LOCUST - TO ST. CHARLES
 SAINT LOUIS

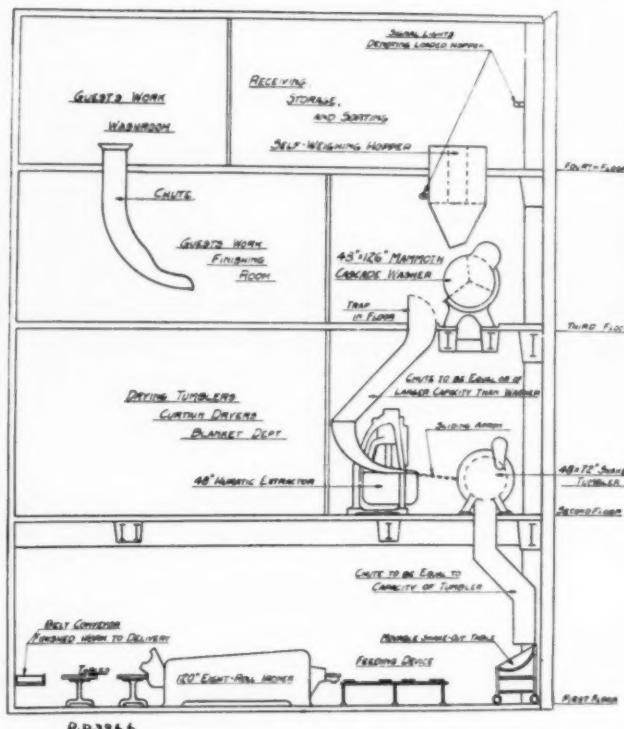


Figure 2. Diagram showing divisions of vertical laundry.

The articles to be laundered are thrown directly into the hoppers by classifiers and as soon as the proper load for the washer has been reached a light flashes, notifying the classifiers and washman in order to avoid overloading.

The goods are then dumped into the large washers directly from the hoppers, without being handled by the operator, thus eliminating the labor usually needed to move the laundry from the classifying room to the washers and likewise the many trucks generally required to carry such large volumes of flat work.

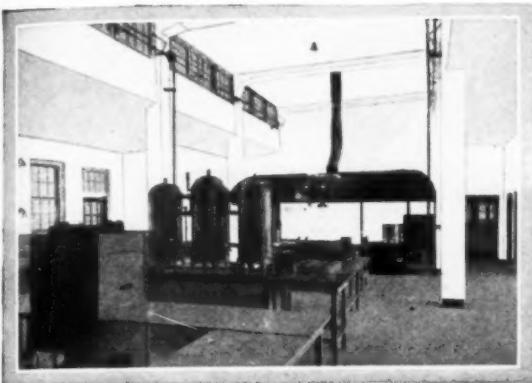
After washing, each of the washer loads is dumped directly into the chute leading the extractor, thus doing away with all labor incident to the unloading of the washers and the trucks to carry the work from the washroom to the extractors.

The clothing dumped into the chute comes down to the second floor, where it is delivered on to a metal table and from there is slid into the 48-inch extractors. The pieces are easily moved from the table between the two extractors to the basket.

After extracting, the work is pulled from the extractors on to the same shelf and, by means of the metal extension of this shelf, which is swung into positions at the proper time, the goods are easily slid into the clothes tumbler. The tumblers, in turn, dump directly into the chutes that deliver the work on to movable shake-out tables, where the pieces are shaken out and prepared for feeding into the ironers, as is shown in Figure 1. The laundry has a battery of three 120-inch, eight-roll flat work ironers and two six-roll ironers, which take care of all the flat work.

With respect to the care of special articles, the laundry has a department where tumbled goods, lace curtains and other special pieces are handled. These articles are handled by a special extractor and when extracted are put into a chute and delivered to the department for tumbling and finishing curtains, on the second floor.

The laundry has a small washer and an underdriven extractor used for the handling of dish towels, wiping rags, shoe cloths and other articles that cannot be handled in sufficiently large quantities to make a load for the large



For a spotless, sanitary finish on walls and woodwork of kitchens, lavatories, laundries, etc., Barreled Sunlight Gloss has proven its superiority. Washes like tile, and doesn't wear away.



For walls, ceilings, and woodwork where conditions require less than a full Gloss finish, Barreled Sunlight Semi-Gloss offers adequate light and durable good looks. Almost as washable as the Gloss.

Durable paint beauty throughout with this famous interior finish

**in Gloss, Semi-Gloss and Flat—
White, or easily tinted**

THERE was a pleasing response from the friends of Barreled Sunlight when we recently presented this famous enamel-like paint in *three different finishes*.

In hundreds of fine buildings where Barreled Sunlight Gloss has been for years an established favorite, the Semi-Gloss and Flat finishes are now welcomed for other interior jobs, either in the pure white or in tint. Being an all-oil product, Barreled Sunlight is easy to tint any desired shade with colors-in-oil.

Barreled Sunlight is so handsome it replaces the finest enamel. It costs less, and is so opaque that fewer coats are required.

There is also a real saving in the labor of application, for

Barreled Sunlight, containing no varnish, flows on freely with brush or spray.

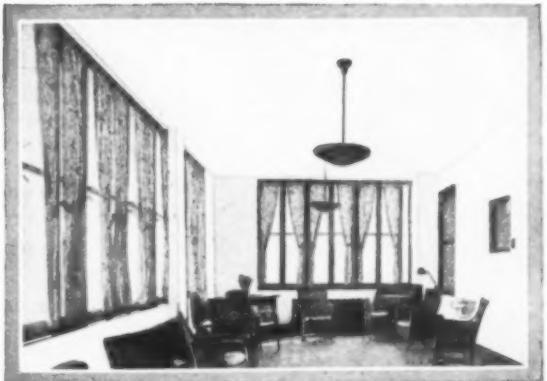
When used in the pure white, Barreled Sunlight resists for years the yellowing tendency common to so many white paints and enamels—an advantage due to the exclusive Rice Process of manufacture.

Sold in 55- and 30-gallon churn-equipped steel drums, and in cans from $\frac{1}{2}$ pint to 5 gallons. Where more than one coat is required, use Barreled Sunlight Undercoat first.

Use coupon to obtain illustrated booklet "Interiors of Lasting Whiteness," and a sample panel painted with Barreled Sunlight.

**U. S. GUTTA PERCHA PAINT CO.
Factory and Main Offices
30 Dudley Street, Providence, R. I.**

New York—350 Madison Avenue
Chicago—659 Washington Blvd.
San Francisco—156 Eddy Street
Distributors in all principal cities



For well-lighted rooms, lounges, lobbies, where "flat" effects are sometimes desired, nothing is more suitable than Barreled Sunlight Flat. Handsome and washable—though naturally less durable than Gloss or Semi-Gloss.

By simply mixing colors-in-oil with Barreled Sunlight white, the painter on the job can easily obtain any desired shade. In quantities of 5 gallons or over we tint on order at the factory, without extra charge. For tinting small quantities our dealers carry handy tubes of Barreled Sunlight Tinting Colors.



**U. S. GUTTA PERCHA PAINT CO.,
30 Dudley Street, Providence, R. I.**

Please send me your booklet "Interiors of Lasting Whiteness," and a sample panel painted with Barreled Sunlight. I am interested in the finish checked here—

Gloss () Semi-Gloss () Flat ()

Name.....

Street.....

City..... State.....

Barreled Sunlight

Reg. U. S.

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FOR ANESTHESIA

Manufactured with the utmost care and its freedom from such impurities as Aldehyde, Peroxide, Acid, etc., renders it the safest and most economical Anesthetic Ether available for surgical use.

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ST. LOUIS
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The Source of Quality Capes at low prices



Finger-tip Length Cape

IT IS no mystery or secret why Standard-sized Tailored Capes sell for such low prices.

First—When you buy Standard-sized Capes they are bought direct from the manufacturer, thus eliminating the profits of jobbers, dealers, stores, etc. Second—The makers of Standard-sized Capes produce Nurses' Outer Apparel Exclusively.

Such concentration of effort naturally results in the highest degree of quality with greatest economy.

ALL Standard-sized Capes are tailored of rich, *all-wool* materials only, in a wide variety of color combinations. Institution's initials embroidered on collar gratis.

Sample Cape sent to institutions on approval.

BUY FROM THE MANUFACTURER FOR LESS



No Uniform Complete Without a Cape

STANDARD APPAREL CO.

Manufacturers

1227 PROSPECT AVE.

CLEVELAND, OHIO

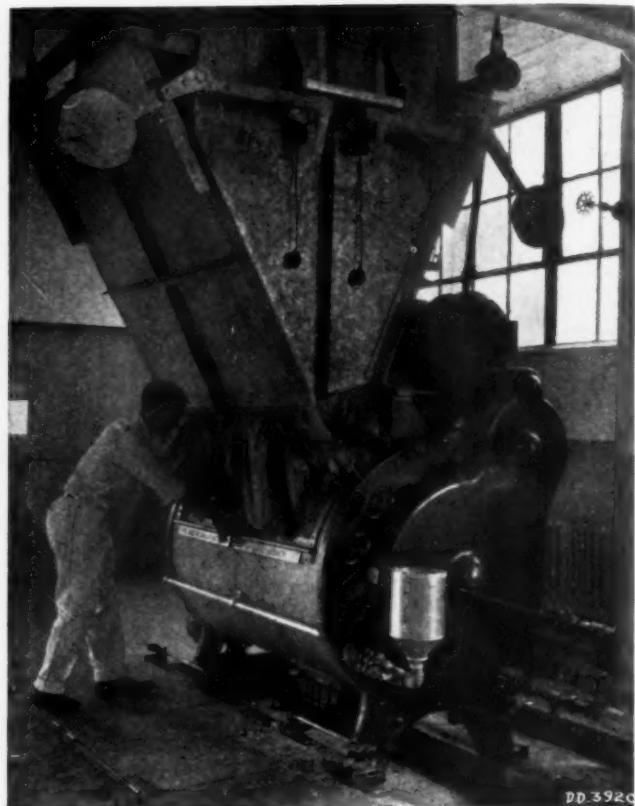


Figure 3. A view of the laundry as it is received by the tumbler.

washers. The size of the loading hopper and the machine are indicative of the type of work done. The machine does not dump, the washman dropping the load into the chute one pocket at a time.

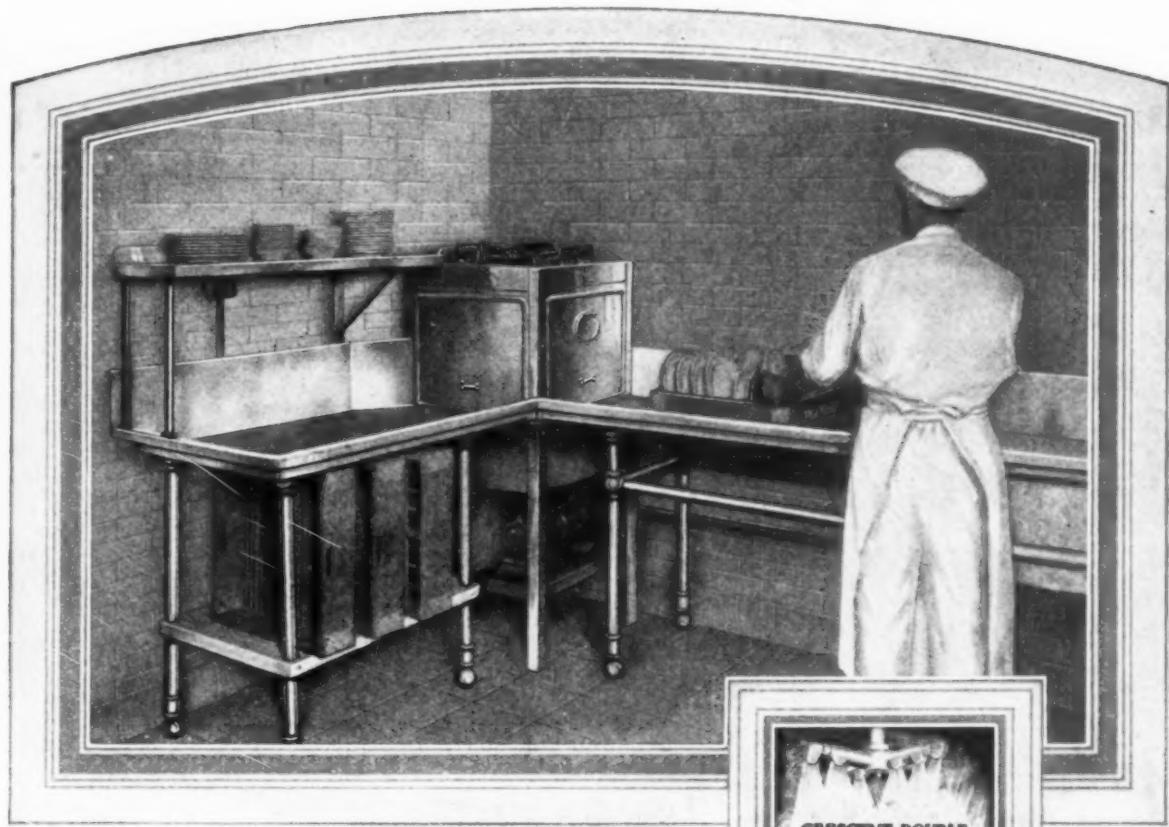
The guests' work department has a marking room where the guests' bundles are identified, shown on the third floor of the diagram. The washroom contains special washers and, after extracting, the articles are conveyed by a chute to the starching and finishing room.

This vertical type of laundry, which includes large capacity machinery, hoppers, gravity chutes, and conveyors, eliminates to a great extent unnecessary handling of pieces, pulling in and out of washers and the trucking to and from departments, and thus materially increases the output per operator.

The economy in floor space alone resulting from the installation of these large machines is great. Three of the large washers occupying a space seven feet wide by forty-seven feet long handle approximately the same volume of work as twenty thirty-six by fifty-four wood washers occupying a space five feet wide by 153 feet long.

The four washers in this laundry handle as high as 21,000 pounds in a nine-hour day with only two men.

Eliminating the labor entailed in loading into and out of the machines and the attendant trucking of the materials between machines, which is the procedure in most laundries, it is possible to handle much larger volumes of work with an expenditure of even less labor. One man can control a great number of washers if all he has to do is to pull a lever that drops the goods from a hopper into the washer in order to load it and open the dumping doors, permitting the goods to drop into the chute, thus unloading the washer. The short time consumed in these operations leaves him sufficient time to attend to the manipulation of the supplies and the water valves necessary to the changing of the various waters during the washing



An Improved Small Crescent at a New Low Price

A SPACE two feet square is enough for the New Crescent Model "AM." It can be placed in any corner, or straight-along-the-wall, in any available spot in kitchen or pantry.

Three doors are provided so that any two can be used, according to the position in which the machine is placed.

The two operating-doors are counter-balanced. They open and close together, gliding up and down at a light touch of the hand.

This does away with the operation of separate doors, and sends the dishes through with greatest ease and speed.

The powerful Crescent Revolving Wash does its work in just a few seconds while the doors are down.

Mass, force and motion of the hot wash water are combined in the fastest and most efficient wash-action known—the perfect washing principle—exclusively Crescent!

All tableware can be perfectly washed, sterilized and air-dried as fast as the racks can be filled.

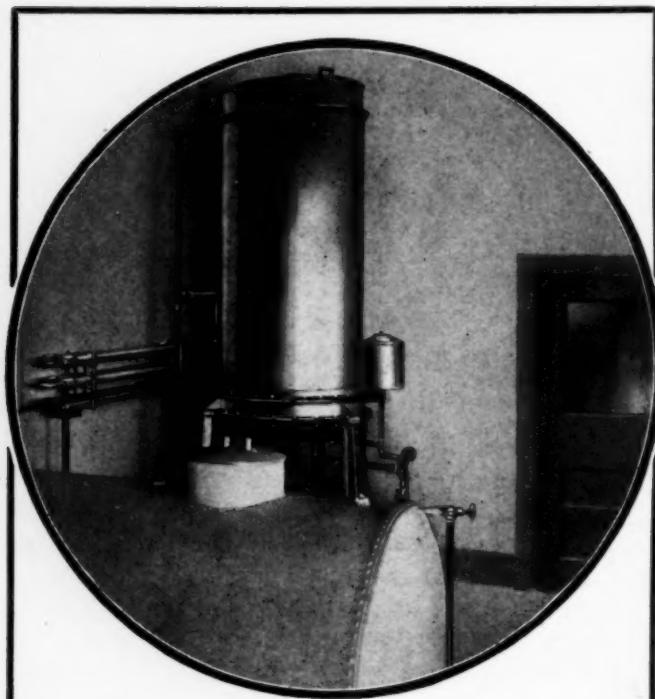
The machine itself does all the work in one easy, rapid, noiseless operation, free from wet floors, splashed clothing, scalded hands and all the other annoyances and effort of old-style dishwashing.

Only the simplest connections are needed for water and electricity. The installation can be made with very little change in any present arrangements.

The guaranteed capacity is 4,000 dishes an hour (or 5,000 glasses) and the prices, for Copper, Monel or Galvanized Iron, are specially attractive.

CRESCEANT WASHING MACHINE DIVISION
(of The Hobart Mfg. Co.) New Rochelle, N. Y.

CRESCEANT Automatic DISHWASHERS



Have You a Troublesome Water Problem?

EVERY hospital without a modern water still is not following out the principles on which it was established. Purity in everything is considered highly necessary. It is not consistent then that a hospital should overlook pure water.

The Precision Nu-Polar Still absolutely ends all water troubles. It gives chemically pure water—superior in palatability to the best known table waters.

The Precision Nu-Polar Still is easy to clean and can be flushed out in 5 minutes. It is guaranteed for 2 years against defective parts. Made in capacities of 5 to 250 gallons per hour.

The Nu-Polar Catalog explains how you can put an end to that troublesome water problem. Where shall we send it?

Precision Scientific Company
830 SOUTH TRIPP AVE. CHICAGO

process. In the operations of extracting and tumbling the difficult labor is eliminated, the charging and discharging of the machines speeded up, and again, a greater output per operator is secured.

A NEW METHOD IN HELIOTHERAPY

Hospitals generally have been quick to grasp the value of sunlight in the treatment of many diseases. We have learned of the remarkable results in bone tuberculosis, obtained by Rollier of Lausanne, Switzerland, and of many others in both Europe and America. The two principal methods of light treatment, or heliotherapy, have been direct exposure to the sun and ultraviolet rays artificially generated.

In the earliest work with heliotherapy it was found that ordinary window glass, while it in no way obstructed light, as we usually understand the term, actually did filter out the ultraviolet rays, the part of the sun's spectrum having particularly healing effect. In the manufacture of ultraviolet lights, this difficulty was overcome by using as a shield for the burner, transparent quartz in place of glass. Quartz permits the ultraviolet rays to pass freely; ordinary glass does not.

In view of the above, it is not surprising that the use of quartz for window panes is now being commercially developed. This material would appear to have application in hospitals of many kinds; especially, perhaps, those treating tuberculosis and skin diseases.

Hospitals in northern climates have been unable to take full advantage of such sunlight as their winter climates afford, because they were unable to keep the patient sufficiently warm when exposing him directly to the sun's rays. This new idea of quartz windows should make such utilization practical.

The quartz glass is furnished in two types:

(a) A glass which gives slight diffusion of light and obstructs vision from outside.

This form is suitable to roofs, walls, etc., where clarity of vision is undesirable.

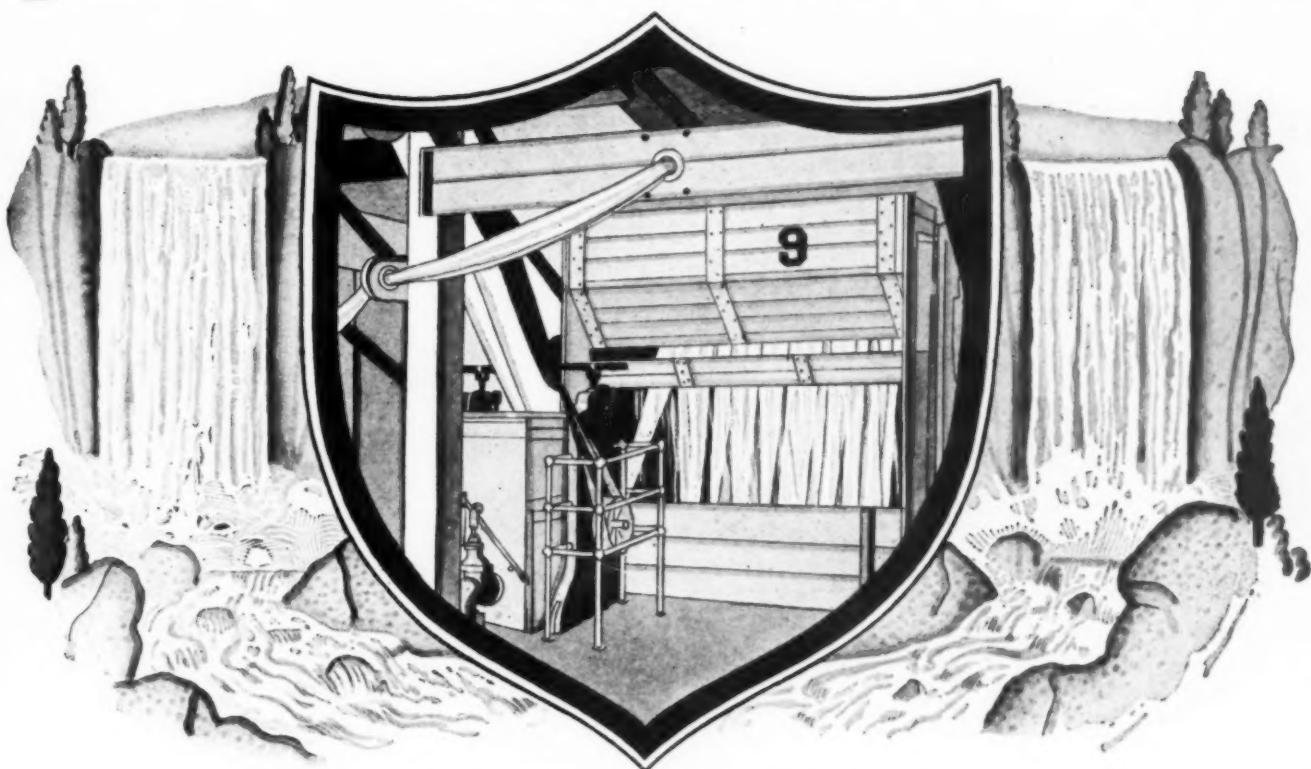
(b) Clear quartz glass which, to all appearances, is like any window pane.

The quartz glass is sold with a guarantee that it will transmit light to the complete limit of the solar spectrum. The initial expense of installation is, of course, more than for ordinary window glass. It is believed that if manufacturers will reduce their production costs to a minimum, they will be able to sell the glass for a price that will not make its use prohibitive, in view of the recognized value of heliotherapy in many diseases.

GAUZE AND BANDAGE CUTTER WITH AUTOMATIC CARRIAGE

A gauze and bandage cutter with self-measuring gauges and an automatic bandage carriage has recently been developed by a manufacturer of hospital supplies. Previous bandage cutters have had a self-measuring gauge, thereby eliminating the marking and measuring when cutting. Thus the operator was always able to secure the proper width of bandage but was required to cut the material at an angle, so that when the bandage was unrolled the sides were not exactly straight.

With the newly developed automatic bandage carriage the operator simply inserts the roll on the carriage attached to the base plate of the machine and feeds it into the machine, and as many bandages can be cut from the



Reason No. 4 for Standardizing on Pequots

BLEACHING

IF you will look at the label on a Pequot Sheet, you will see the words: "Danvers Bleachery." Those two words guarantee that the Pequot Sheet has had the famous "Danvers Finish"—a finish which the whole textile industry admires but has never been able to imitate.

The "Danvers Finish" assures the permanent whiteness and the soft, pleasing feel of Pequots. It assures, also, that the exceptional strength and durability of the Pequot fabric has been retained, because injurious chemicals are never used in the Danvers Bleachery.

An important factor in the "Danvers Finish" is the torrent of pure artesian well water used in bleaching.

But more important than water or chemistry are the years and years of skill, experience and pride which have evolved this "Danvers Finish." It is a priceless heritage of honest workmanship.

ONLY in Pequots can you secure the "Danvers Finish." You can safely standardize on Pequots.

Made only by the Naumkeag Steam Cotton Company, Salem, Mass. Parker, Wilder & Co., New York and Boston, Selling Agents.

STANDARDIZE ON



HENRICI

Exclusive design of HENRICI cylinder ensures maximum agitation of water - quickest and most thorough washing.

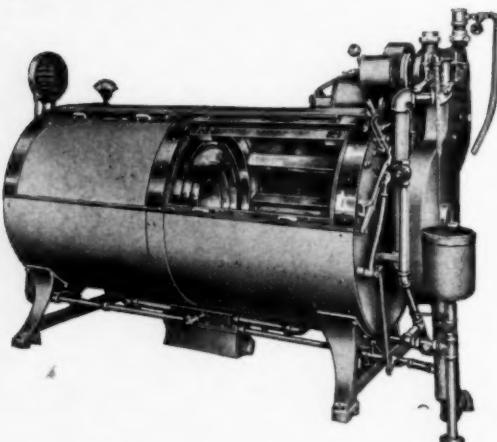


Sugar melts slowly in a still cup of coffee—likewise, dirt is dissolved more slowly in a washer with a round cylinder which does not give proper agitation.



Sugar melts quickly when the coffee is stirred, likewise, dirt and soluble matters are removed from clothes quickly when subjected to maximum agitation in the Henrici Washer.

THE Henrici 30% perforated cylinder gives freest possible circulation of water. The flat cylinder sides give maximum agitation, forcing water in and out of the cylinder and through the innermost folds of the clothes. Compare the Henrici with any other cylinder made, and you will see why Henrici Washers are so efficient and economical.



HENRICI LAUNDRY MACHINERY CO., Boston 26, Mass.

HENRICI WASHER
SPEEDY - ECONOMICAL - DURABLE

thirty-six inch bandage roll as the operator can feed into the machine.

The width of the bandage is indicated on the device by a measuring gauge installed thereon, so that the finished bandages turned out by the cutter are straight with a clean, unravelled edge and are ready for immediate use.



As the machine weighs only sixteen pounds it is easy to handle, readily portable and detachable, since only one screw is required to connect it with the machine. When it is desired to cut flat dressings the bandage carriage is removed and the self-measuring gauge for cutting flat materials is attached.

ULTRAVIOLET LIGHT GLASS HANDLED BY AMERICAN AGENT

A recent issue of THE MODERN HOSPITAL carried an article entitled "What is the Best Medium For Transmitting Ultraviolet Light?" This dealt with the window glass substitutes for the transmission of ultraviolet rays in sunlight. The various mediums such as fused quartz, acetone cellulose, and the flexible Austrian product were mentioned and there was one paragraph which in the light of recent developments should be corrected.

The paragraph in question read:

"In England a glass has been developed than transmits a large percentage of the ultraviolet rays. This is a quartz composition harder than ordinary window glass and is made with different degrees of transparency. It may be obtained in sizes similar to ordinary window glass for about four pounds sterling per square foot."

The glass referred to is now being handled by a New York firm that is the sole American agent. The production is now standardized and the glass is made in two types. The American company offers this glass at slightly over a dollar per square foot instead of four pounds sterling, as stated.

December, 1926

THE MODERN HOSPITAL

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Director's Home



Boys' Cottage



Administration Building



Girls' Cottage



Power Plant

MARSH FOUNDATION
Van Wert, Ohio

Plumbers
The Carey & Hall Company
Architects
Langdon, Hohly & Gram

Leading The Trend Towards Absolutely Perfect Sanitation



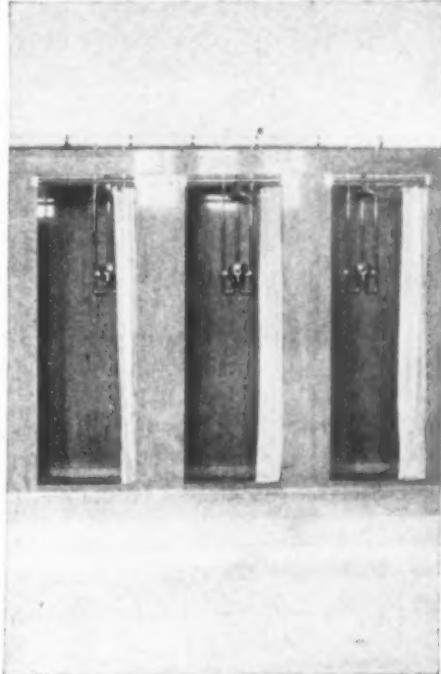
ITH each advancing decade, the need for perfect sanitation in schools and hospitals has become more and more apparent.

Upon those in charge of such institutions rests the responsibility of securing only the best proven plumbing — plumbing that will safeguard the health and lives of the school children and patients — plumbing that will pass the financial tests of time and wear.

It is because of these things that so many modern schools and hospitals are equipped with Clow plumbing throughout.

The Marsh Foundation at Van Wert, Ohio, is a notable example. All five of the buildings shown on this page are completely equipped with Clow Plumbing — to preserve and maintain close-to-perfect sanitation and to obtain the operating, maintenance and replacement economies that only well-designed, well-built plumbing can effect.

Everywhere Clow is leading the trend towards absolutely perfect sanitation.



*A Section of the Boys' Showers
Marsh Foundation*

JAMES B. CLOW & SONS

201-299 N. Talman Ave.

CHICAGO

Offices in Principal Cities

CLOW

PREFERRED FOR EXACTING PLUMBING SINCE 1878

A recognized ally of the profession

PHYSICIANS know they can rely upon Kellogg's ALL-BRAN because it is 100% bran. 100% effective both in relieving constipation and in preventing it.

That is why more and more physicians are recommending ALL-BRAN in the diet. Kellogg's provides the bulk or "roughage" necessary to correct faulty elimination in a generous quantity no part-bran product can possibly equal.

Cooked and krumbled by a special process—Kellogg's has a particularly delicious flavor. There are many appetizing ways of serving it. As a ready-to-eat cereal—or in cooking. ALL-BRAN is a prescription that any child will delight in taking.

Made by Kellogg in Battle Creek, Michigan. Sold by all grocers. Served everywhere.



What U.S.P. is to drugs, ALL-BRAN is to bran foods.

Send to the Kellogg Company, Battle Creek, Mich., for recipes and health pamphlets.

Kellogg's
the original ALL-BRAN
—ready-to-eat

Panes in any required size up to approximately 3 x 5 feet in the clear glass, and 3 x 8 feet in the Cathedral or diffused glass, can be supplied cut to the exact measurements. It has recently been installed in several hospitals and sanatoriums in the United States, and interesting results, comparable with those obtained in England, are anticipated.

A PORCELAIN ENAMEL TILE FOR WALL SURFACES

A vitreous porcelain enamel tile, recently manufactured, lends itself to practical usage in the hospital. The tile is of the same material that is used in the manufacture of bath tubs and is of the chemical composition that will withstand the ordinary agencies of corrosion.

The surface will not crack or check, according to the



manufacturers, and the product is supplied in tile of pure white or colors, if desired, and the cost is about half that of ordinary tiling.

The simplicity of the installation of these tiles is such that any mechanic of average ability can do the work. The base for installing is insulated material containing a series of grooves. The base is then fastened to the studding or the walls and the grooved flanges of each unit tile fit into the grooves of the base, which are filled with a special cement. The wall thus formed by the construction is insulated against heat or cold, is easily washed and when kept clean, presents a sanitary appearance.

AN INEXPENSIVE WAY TO BEAUTIFY THE HOSPITAL

At a recent visit to one of the large tuberculosis sanatoriums in New York State, the editor of the department on hospital equipment and operation was favorably impressed by a simple means that had been used to beautify the institution and to make it more homelike.

The proverbial plainness and sameness of the hospital's walls was completely dissipated by the judicious use of dozens of colorful pictures. Upon first glance it appears to the visitor that the cost of these pictures must be prohibitive for the average institution. It was ascertained, however, that the prints themselves had been obtained entirely free of charge from both American and foreign railroads, from steamship lines, and other corporations who are employing modern, artistic methods in their advertising. These posters, many of which are beautifully colored, look well when framed and entirely disprove the supposed need of paying a high price for presentable pictures.

December, 1926

THE MODERN HOSPITAL

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PYREX ware looks—and is—attractive and sanitary. It can be sterilized without danger of breaking

PYREX ovenware is made in small sizes, permitting individual service to meet special needs. It permits baking and serving in the same dish



TESTS . . .

by experts show that foods
bake better in this ovenware

IN the country's greatest cooking school tests were made recently to determine the comparative efficiency of different kinds of ware.

Dozens of foods were baked in the various utensils commonly used in baking.

The results were overwhelmingly in favor of *PYREX ware, adding greater baking efficiency to the already recognized advantages of this ideal ovenware.

The tests showed that PYREX ware distributes the oven heat more efficiently—browning the crust more uniformly, baking the inside more thoroughly, more evenly.

* * *

PYREX dishes insure not only more healthful, more uniform baking results but greater efficiency and convenience in serving and preparing as well.

For, with its remarkable heat retaining properties, PYREX ovenware prevents too

rapid cooling—an important factor when foods must be carried some distance.

Smooth, transparent, with all angles and corners rounded, PYREX ovenware is easiest to keep spotlessly clean. Resistant to high temperatures and to sudden cooling, it can be sterilized constantly without danger of cracking or breaking.

PYREX ware permits the time-saving convenience of baking and serving in the same dish. It is made in sizes small enough for individual service to patients with special dietary needs. PYREX ovenware looks—and is—sanitary and attractive. It will never stain, discolor, nor show traces of wear—will give long, efficient, and economical service.

* * *

Due to their remarkable resistance to heat, to sudden cooling, to chemical action and to electric current, PYREX products have important hospital uses. Complete information regarding PYREX hospital equipment will be sent on request.

*PYREX nursing bottles
can be sterilized without fear of breaking*

CORNING

CORNING GLASS WORKS

CORNING, NEW YORK

*T. M. Reg. U. S. Pat. Off.





The
GEORGIAN
*A Popular
Stock Design*

THE Georgian is an exclusive Iroquois Stock Pattern that has attained great popularity.

It is a good example of the attractive designs for which Iroquois China is noted.

Special designs made to order when desired.

Iroquois is a high grade American Vitrified China—made for service as well as appearance.

*Iroquois China is sold by good jobbers
in all sections of the United States.*

IROQUOIS CHINA COMPANY, SYRACUSE, N. Y.
Hospital, Hotel and Restaurant China Exclusively

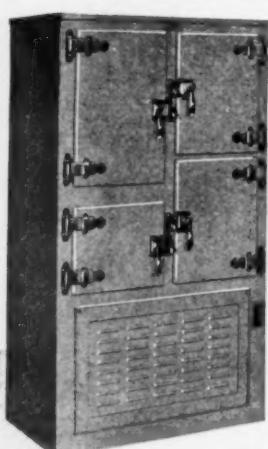
IROQUOIS CHINA



Hospitals demand that food be properly preserved

Thesco Refrigerators are noted because they do keep so as to avoid spoilage and maintain nutrition. food products fresh and wholesome.

*"Always High in Quality
And Low in Temperature"*



is the reputation earned by Thesco Refrigerators through unusual service records. Representative hospitals throughout the Country install Thesco Refrigerators both in their general as well as in their diet kitchens.

DESIGNED FOR EVERY PURPOSE, THERE IS A THESCO TO MEET YOUR NEEDS.

Over 50 years experience enables our advisory engineers to give you the benefits of real service.

Ask us any questions.

Every hospital should have Catalog M-84

It is a valuable reference. Write for your copy now.

THE C. SCHMIDT CO.

Estab. 1870

John and Livingston Street

CINCINNATI, OHIO

The State Hospital at Raybrook, N. Y., is said to have originated this plan. In framing, all of the printing and advertising matter is eliminated and a suitable size of frame is fitted to the poster. A few views which are familiar and which have been used with fine effect are those of Lake Louise and Banff in Canada, and also pictures of the Alps, Venetian scenes, and views of France and other countries. The high coloring is attractive and at the same time has a definite cheering effect. It is possible for hospitals to buy picture molding in considerable quantities at small cost and do the framing in their own carpenter or occupational therapy shops. The only appreciable expense is the cost of glass. The idea is presented as well worth following by hospitals generally.

A MULTI-COLORED CORK COMPOSITION FLOORING

The demand for resilient floors in hospitals and other institutions has led to the development of a cork composition flooring that is durable and easy to keep clean.

The newest development of this type of flooring is a cork tile combining the beauty of multi-colored marble shadings and the comfort and durability of cork composition.

The floors are installed tile by tile, the size of tile being selected in accordance with the size of the room. The cork construction of the flooring makes it easy to keep clean by washing and offers a surface that is conducive to a wax finish. The tiles are both resilient and noise-absorbing.

A STEEL CASTER WITH SPRING SOCKET

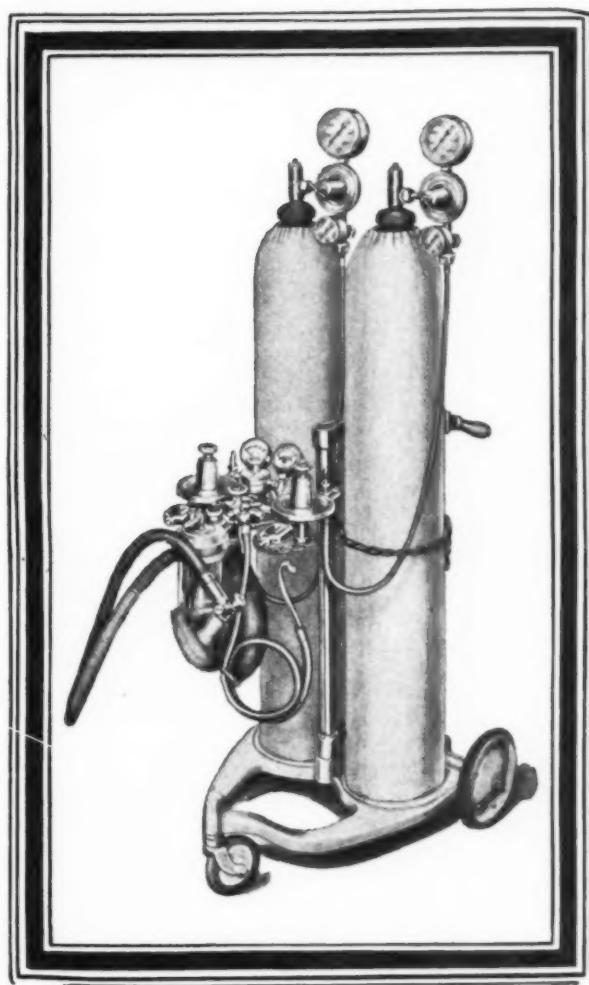
The new pressed steel caster, illustrated here, is designed for use on beds and other hospital equipment. This type of caster has been developed in different sizes and the special three-inch size with spring socket has been quite generally adopted as standard among manufacturers of hospital equipment.

The neck of the caster is so designed with spring projections that it fits snugly and does not slip or drop out of place when beds are moved. The rubber tires, which are of the renewable or non-renewable type, make it impossible for wheels to slip, work loose or become dislodged. The bearings are of heavy brass composition that insures easy and quiet operation.

The five-inch wheel caster of this type is becoming popular for hospital beds, as the larger wheel makes the bed as mobile as a wheel chair, greatly facilitating the quick movement of the furniture.



because it is accurate and has every practical device for the elimination of error, the "Heidbrink" Model T is preferred by experts, and chosen by beginners for quick mastery of anesthesia.



Note the "right-at-hand" control—on top within easy reach . . . the accurate sight-feed indication of dosage always in full view . . . the Selective Emergency Valve that gives absolute **emergency** control by means of a single instantaneous manipulation. Every mechanical device is for Safety . . . for Efficiency . . . for Successful Anesthesia.

These are but a few of the exclusive features. Write for our Free Catalog 6 which tells about the others

The HEIDBRINK COMPANY
Minneapolis, Minnesota, U. S. A.



The BEST COOKS use Aluminum

What is the lesson today? Is it on baking, or stewing, or roasting, or frying? Is it on cherry cobbler, or clam chowder, or chocolate cake?

Whatever it is, you may be sure of one thing. Should the question arise as to what utensils are best, the instructor will say, "Of course, aluminum cooks everything well."

In the home economics departments of our schools

Write for Pamphlet. "Aluminum and Aluminum Ware" is the title of a recently published review of the latest scientific researches into the nature and uses of aluminum and the character of aluminum cooking utensils. A copy will be sent free.

and colleges, in the famous testing institutes of our women's magazines, aluminum cooking utensils are used for every kind of cooking and preferred for their

durability, economy, beauty, and safety.

And the same is true in great hotels, in hospitals, on railroad dining cars, on palatial ocean liners, and in millions of homes. . . .

The best cooks use aluminum.

A L U M I N U M W A R E S A S S O C I A T I O N
Publicity Division, 844 Rush St., Chicago

Book Reviews and Current Hospital Literature

REVISED UNIFORM SYSTEM OF HOSPITAL ACCOUNTS¹

The fourth edition of the "Revised Uniform System of Hospital Accounts" represents a refinement of a plan of hospital accounting adopted by London hospitals in 1906.

The revision was made necessary by the extreme financial straits in which hospitals of England found themselves during the post-war period and was effected in joint council between the late John G. Griffiths, F.C.A., and a committee of hospital secretaries, after full consultation with the British Hospital Association, the Incorporated Association of Hospital Officers, and the three London hospital funds. The hospital economy committee of King Edward's Hospital Fund was instrumental in developing methods of internal control of expenditures by means of quantity statistics, the budgets and departmental costs.

The revised text is of interest as the latest effort to bring hospital accounting into line with present day requirements. It has not lost sight of the fact that the hospital is not a profit-making concern and that its statistics are published as much to stimulate intelligent public interest in hospital affairs as to control outlay. The published accounts of the hospital should show the supporters of the hospital how their contributions have been utilized as well as the financial position of the hospital.

The main body of the text presents the prescribed forms of reporting and is explicit regarding new regulations and explanatory provisions that are effective in reports during 1926. No rules are laid down as to methods of bookkeeping, but facts are specified that it is essential to bring out for purposes of budgetary control.

General interest in the volume will be aroused chiefly by the progress in hospital finance made by the Hospital Economy Committee. Three phases of hospital economy are discussed: Quantity statistics; the budget and departmental costs. The prices paid by hospitals for commodities depend upon the size of the hospital and upon location. Fluctuating prices and increased expenditures do not necessarily indicate when increased quantity consumption has taken place. Economical buying may be more than counterbalanced by excessive consumption, and loss takes place when adequate means of recording and reviewing quantities are lacking. Stores are just as much an asset as cash, and for every duty imposed upon a cashier with reference to cash there should be imposed upon a storekeeper a corresponding duty with reference to stores.

One ward may habitually consume commodities double those of a neighboring ward. A mere record of total quantities consumed by the hospital will not suffice. Commodity expenditures figured in 100-patient day units will

¹ George Barber, London, 1926.

To general practitioners—when in doubt

Have radiographs made

Naturally this does not apply to all diagnosis but there are many times when x-rays will definitely show the way. In tuberculosis, suspected cancer, cholecystitis and gastro-intestinal complications the x-ray findings are generally conclusive. Fractures and osteosis are, of course, positively shown.

Hospitals and roentgenologists will gladly co-operate with you. You owe it to yourselves and your patients to take advantage of these facilities.

X-rays mean more certain diagnosis.

Eastman Kodak Company

Medical Division

Rochester, N. Y.



No other cereal can be used in so many different ways

FOR THE VERY SICK

1. Cream of Wheat with broth
2. Thin gruel
3. Plain cereal

FOR BABIES

1. Cereal Water
2. Thin or thick gruel

FOR CONVALESCENTS

1. Breakfast cereal—with fresh or stewed fruit, dates, raisins, figs, prunes; brown sugar; butter; poached egg
2. Dainty, nourishing desserts, as apple pudding
3. Vegetable dishes, as baked stuffed tomato
4. Meat dishes, as escalloped ham

Cream of Wheat is invaluable in this: *every patient can eat it in some form!* Physicians advise it because of its exceptional carbohydrate content and because it is so easy to digest.

It has the advantage of combining particularly well with other foods. By using cooked Cream of Wheat as the base for a number of different dishes, you can get the tempting variety and the necessary food values you want in your menus, and keep well within your buying budget.

One box gives 40 generous servings; and you never have waste because there is never any spoilage with Cream of Wheat. It is safeguarded from contamination as no other cereal, in its triple-wrapped-and-sealed box.

For a variety of delightful ways to serve this dependable food send for our recipe book, "50 Ways of Serving Cream of Wheat." Sent free.

FOR 30 YEARS A STANDARD FOOD ON PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minn.
In Canada made by Cream of Wheat Company, Winnipeg

© C. of W. Co., 1926

enable those in authority to locate excessive consumption. It will also encourage economy among the nursing, departmental and administrative staffs. The average administration, lacking departmental commodity budgets, gives the careful person no incentive to continue his economy and the wasteful person no check on his extravagance.

Budgetary control (thinking ahead in terms of expenditure on the basis of periodical estimates of income and costs) is ineffectual without provision for placing definite responsibility on department heads for keeping expenditures within approved limits. Cost and commodity reports, then, must permit cost finding per bed for each service, direct and indirect. The wide range of expenditure for patient care does not represent differences in food and physical comforts for the patient so often as it indicates the addition of special sections of work rendered necessary by modern developments of medicine and surgery. Few hospitals are able to declare on the basis of their accounting systems whether such additions represent essential services properly elevating costs per bed per diem, or whether they represent a generous policy of administration unjustified by net results. The appendix to this volume gives graphic methods of making clear the system of analysis recommend in the aid of internal hospital economy and shows how the cost per unit of work done can be effectively compared with the past experience of the hospital concerned and that of other hospitals.

FUNDAMENTALS OF DIETETICS

BY BERTHA M. WOOD and ANNIE L. WEEKS*.

"Fundamentals of Dietetics," by Wood and Weeks, recently published, outlines a course of instruction much in detail. The course is divided into two sections, a preliminary and an advanced course, totaling sixty-nine hours of class work.

A complete plan for each lesson is presented, including an outline of points presented, instruction on the subject and amount of food material necessary for twelve students. The dietitian who must spend long hours in her department every day, and whose hospital provides no library for her use, will find the book a solution of her problem. The lessons are logically planned and include the general facts and factors in food dietetics that a nurse should know.

This book together with "Talks to Nurses on Dietetics and Dietotherapy," by Ruth and Helen Wheeler, a review of which will appear in these columns next month, may well be used in a supplementary way, thereby covering the subject comprehensively.

We hope that Saunders, or some other publisher, will now find an author who is willing and competent to give us a book that will answer the numerous questions constantly coming from physicians, dietitians, nurses, and others about actual food materials, particularly vegetables of various kinds and the many food materials more recently coming into common use.—L. G. G.

BOOKS RECEIVED

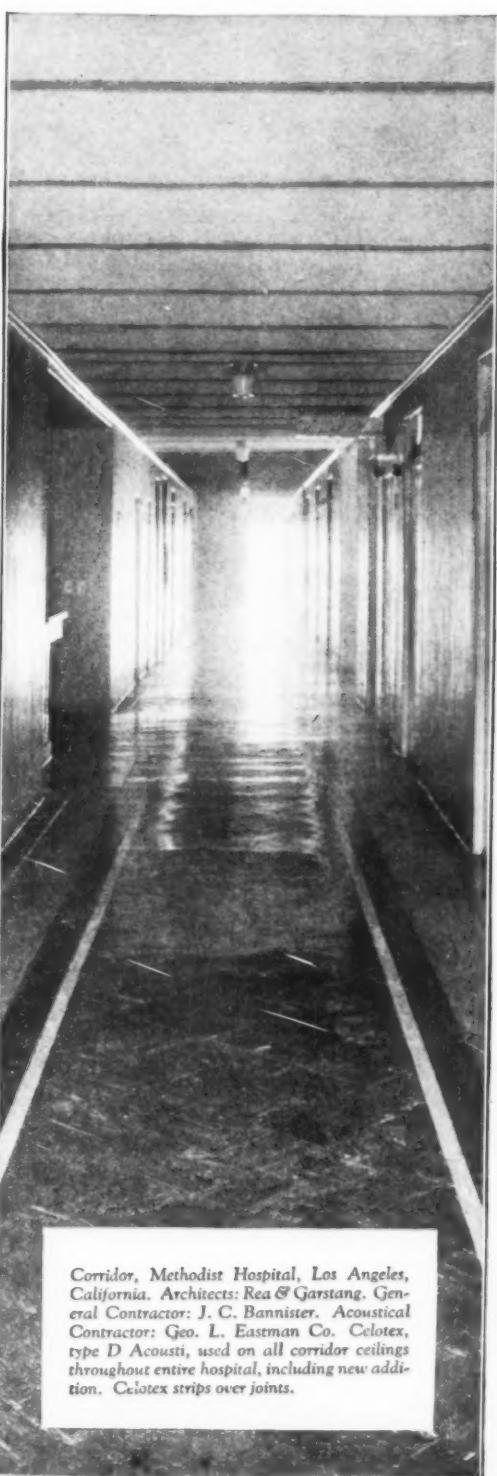
TEXTBOOK OF ANATOMY AND PHYSIOLOGY, by Diana Clifford Kimber, graduate of Bellevue Training School; formerly assistant superintendent, New York City Training School for Nurses, Welfare Island, N. Y.; formerly assistant superintendent, Illinois Training School, Chicago, and Carolyn E. Gray, A.M. (Columbia University), R.N. Seventh edition, revised. The Macmillan Company, New York, 1926.

*W. B. Saunders Company, Philadelphia, 1926.

December, 1926

THE MODERN HOSPITAL

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Corridor, Methodist Hospital, Los Angeles, California. Architects: Rea & Garstang. General Contractor: J. C. Bannister. Acoustical Contractor: Geo. L. Eastman Co. Celotex, type D Acousti, used on all corridor ceilings throughout entire hospital, including new addition. Celotex strips over joints.

now—a beautiful interior finish that *keeps out* heat and cold, *quiets* noise . . .

This remarkable heat-stopping lumber provides comfort and quiet in hospitals at little or no extra cost. Allows unique decorative effects.

Men who specialize in hospital building have long been seeking a practical soft-textured finish to replace harsh, glaring walls. Now, they have found in Celotex Insulating Lumber an ideal interior finish that also gives vital protection to patients from draughts, temperature changes and noise. Where advisable, Celotex can be plastered, painted or faced, so as to provide for routine cleansing and disinfecting. Celotex is a special lumber manufactured from the tough fibres of cane. It is made to keep out summer heat and winter cold—to shut out wind and moisture—to deaden sound. It strengthens the building, cuts repair bills and reduces heating costs about $\frac{1}{3}$.

Little or no extra cost

The use of Celotex costs little or nothing extra and is practical in old and new buildings alike.

As interior finish on ceilings, Celotex is used as shown. It is applied directly to the interior framework and either left in its attractive natural tan finish or decorated.

As sheathing, Celotex replaces wood lumber, giving the insulation needed back of

brick, stucco or wood exterior walls. It also takes the place of lath on inside walls and ceilings where plaster is applied directly to its surface.

For quieting noise

A special form of Celotex—Acousti-Celotex is used on corridor ceilings to absorb sound. This type of Celotex is a highly efficient acoustical material as well as an insulator. It is useful in quieting noise in delivery rooms, nurseries, elevator lobbies, serving kitchens and many other places.

A free service to hospitals

The expert engineers of our Acoustical and Service Departments will co-operate in working out the proper uses of Celotex in your institution. Their services are free.

Also ask your architect, consultant, contractor or lumber dealer to tell you more about Celotex. All lumber dealers can supply it. Building authorities advise its use in modern hospitals.

Mail the coupon for free booklets describing its uses and advantages.

THE CELOTEX COMPANY, CHICAGO, ILLINOIS

Mills: New Orleans, La.

Branch Sales Offices in many principal cities—(See telephone books for addresses)

Canadian Representatives: Alexander Murray & Co., Limited
Montreal, Toronto, Halifax, Winnipeg, Vancouver

CELOTEX

INSULATING LUMBER

THE CELOTEX COMPANY, Dept. T-292
645 N. Michigan Avenue, Chicago, Ill.

Please send more information about Celotex Insulating Lumber and Acousti-Celotex.

Name _____

Hospital _____

City _____
Mod. Hosp. 12-26

State _____

Good— Rubber Goods

In Every Hospital—Quality and Durability Are the True Guarantors of Service and Economy



WHEN YOU select rubber sheeting ask yourself these questions: Will it wear? Is it serviceable? Does the manufacturer stand behind his claims? Is it economical? When you have these elements in mind measure them with Universal Invincible Guaranteed Double-coated Maroon Sheeting. It is built for wear—long and lasting usage such as only the hospital can appreciate. It is soft and pliable and will not crack, peel or wrinkle. It outwears the ordinary sheeting many times, and so efficiently, that we are glad to stand behind it with a five-year bed service guarantee. These things should be considered. They promise savings to your institution, satisfaction to the nurse and comfort to the patient. In fact they encompass every factor and will relieve your mind in this one important detail which often becomes quite a problem if neglected. Our name is moulded on the selvage of each yard for your protection.

Quality

Back of every Universal product is a faultless quality, the result of years of ceaseless vigor to bring each detail to the highest degree of perfection. When your order is placed in the mails you have the satisfaction of knowing that your goods will be received in excellent condition and will more than meet with your expectations.

Price \$2.00 per square yard. Rolls 25-50-100 yds. 36"-45"-54" widths.

May we send you our complete catalog of guaranteed hospital supplies and equipment?

Universal Hospital Supply Co.

500-510 N. Dearborn St., Chicago, Ill.

NEWS OF THE HOSPITALS

Connecticut

The cornerstone of the new St. Luke's Convalescent Hospital, Greenwich, Conn., was laid October 30.

Illinois

The cornerstone of the new Chicago Memorial Hospital, Chicago, was laid November 3. The hospital will carry on the traditions of the Old Hahnemann Hospital, which it supplants. It is expected that the building will be ready for occupancy by March 1.

Ground was broken November 1, for the new \$500,000 addition to the Municipal Tuberculosis Sanitarium, Chicago.

A new clinic provided especially for the treatment of colored patients was opened at 3736 South Michigan Ave., Chicago, November 15. The clinic will be maintained under the direction of Dr. U. G. Dailey and staff.

Indiana

Construction of the William H. Coleman Hospital for Women, the new unit of the Indiana University Medical Center, Indianapolis, was recently begun and the building will be ready for occupancy by the summer of 1927, according to present plans. The hospital is the gift of Mr. and Mrs. William H. Coleman, Indianapolis, in memory of their daughter, Suemma Coleman Atkins. The building will be used exclusively for obstetrical and gynecological cases and will have a capacity of 75 beds.

Michigan

As a memorial to his three children who have suffered violent deaths during the past six years, Murray W. Sales, Detroit, has donated \$100,000 for a new hospital for children in Grosse Pointe Farms, completing the \$250,000 fund needed for the project.

Minnesota

The Children's Hospital, St. Paul, announces two gifts for its endowment fund: one of \$35,000 from Mrs. W. H. Howard, Pasadena, Calif., and one of \$10,000 from Mrs. C. A. Severance, St. Paul.

Mississippi

The Mississippi State Hospital for the Insane, Jackson, was recently damaged by fire.

Missouri

The St. Francis Hospital, Washington, will be ready for temporary use about December 15, according to a recent announcement. It is a three-story building with a capacity of fifty beds, and will be operated by the St. John's Hospital Association, Springfield, Ill., under the management of the Franciscan Sisters.

Montana

The Kennedy Deaconess' Hospital, Havre, was recently dedicated.

\$815,000 given to



Millard Fillmore Hospital at Buffalo

For years the directors of this fine hospital needed more room but hesitated to put their needs before the people of Buffalo.

Finally, with doubt in their minds as to the outcome they arranged for a Ward, Wells, Dreshman and Gates Campaign.

\$750,000 was the Campaign goal.

\$815,013 was subscribed in less than a week, and the campaign was concluded in one day less than the allotted time.

xxx xxx

Now the Children's Hospital in Buffalo is about to go out in the same field for a similar amount—\$750,000. Their campaign, January 22-31st, also will be directed by Ward, Wells, Dreshman and Gates.

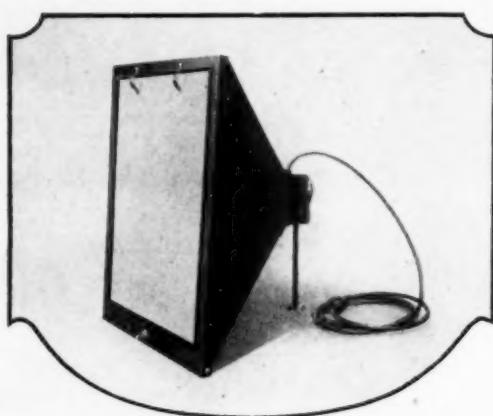
If you are interested in financing your hospital needs, write to either the Millard Fillmore or the Children's Hospital at Buffalo and ask them.

WARD, WELLS, DRESHMAN & GATES

475 FIFTH AVENUE
NEW YORK, NEW YORK

612 WRIGLEY BUILDING
CHICAGO, ILL.

Originators of the Intensive Method of Fund Raising



The Keleket Single Illuminator

will give you

Correct Intensity and Distribution of Light

YOU can now get the maximum diagnostic value of a negative. With a Keleket Single Illuminator, both the direct and reflected light of the high candle power daylite lamp passes through the opal glass and is diffused, giving an intensity that produces the best diagnostic effects.

It is equipped with a universal bracket for mounting on a wall, desk, or filing cabinet. Being built of steel, it requires a very limited space, and comes fully equipped with lamp, switch, extension cord and plugs. This is only one of the many Keleket X-ray accessories preferred by the leading practitioners of the nation.

Other Keleket accessories are:

Aerial tubing and fittings, books for reference work, Bucky diaphragms, cassettes, cathode connectors, chemicals, compression bands, cones, Coolidge tubes, dark room equipment and supplies, drying racks, eye localizers, films, film filing envelopes, foot switches (with or without light controls), head rests, head tables, illuminators and stereoscopes, interval timers, meters, protective materials and equipment, plate chests, reels and attachments, relays and circuit breakers, safe lights, screens, sphere gaps, tables (radiographic or fluoroscopic), tube racks, tube shields—everything for the Roentgenologist.

Our representative in your territory will be glad to serve you—or write

THE KELLEY-KOETT MFG. CO., INC.

219 W. Fourth Street
Covington, Kentucky, U. S. A.
"The X-ray City"

Keleket
X-RAY EQUIPMENT

St. Joseph's Hospital, Lewiston, is constructing a three-story addition for its maternity department.

New Mexico

The Santa Fe Railway Medical and Surgical Society recently met at Albuquerque, on which occasion the new \$300,000 hospital of the Santa Fe Railway Employees' Association was dedicated.

New York

The new thirteen-story addition to St. Vincent's Hospital, New York, was dedicated by Cardinal Patrick Hayes, October 30. The building contains 175 rooms, class and demonstration rooms, and an auditorium seating 350 people.

The Genesee Hospital, Rochester, recently opened its new five-story pavilion, which forms the north wing of the hospital.

The new three-story Mercy Hospital, Watertown, was recently opened to the public.

Immediate plans for the construction of the new Lutheran Hospital of Manhattan, New York, call for an eight-story unit with a capacity of 200 beds.

The New Park West Hospital, New York, was recently opened, under the medical direction of Dr. Harold M. Hays.

North Dakota

The new \$281,000 addition to the Trinity Hospital, Jamestown, was recently opened to the public. The addition contains five stories and includes a new boiler room, a large modern laundry, electrical refrigeration throughout, a filtering and softening water plant and a complete ventilating system. New x-ray equipment has also been installed.

Pennsylvania

Contract has just been let by the State Department of Health for the first unit of the Pennsylvania State Hospital for Crippled Children, at Elizabethtown.

The new children's ward of the Harrisburg Hospital, Harrisburg, was recently dedicated. The ward is a memorial to Dr. Maud Conyers Exley. The simple ceremonies were featured by brief addresses from Frank Brooke, superintendent, and Dr. John B. McAlister.

The \$33,000 estate of the late Mrs. Martha E. Stockton, Philadelphia, is devised in trust for the benefit of a son and daughter and upon the death of the last survivor, the principal is to revert in equal shares to the Howard and Northwestern Hospitals, to endow free beds.

A bequest of \$5,000 to the German Society of Pennsylvania, to be used to establish a free bed in the Lankenau Hospital, Philadelphia, was contained in the will of William Schoelgen, Philadelphia, who died recently.

The Harrisburg Polyclinic Hospital recently dedicated its new four-story building and a new nurses' home when a reception was held for the professional men of the community. All of the departments have been recognized and the laboratories have been fully equipped.

The Germantown Dispensary and Hospital was formerly dedicated October 21. The new six-story buildings include a private patient building and a staff building erected at a cost of \$1,600,000. The total capacity of the building is now 268 beds.

South Carolina

The new St. Francis Xavier Infirmary, Charleston, the new seventy-five bed hospital under the direction of the Sisters of Mercy, was recently opened to the public.

December, 1926

THE MODERN HOSPITAL

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"The Hospital is the Community Keystone"

The three institutional foundation stones of any community are the church, the school, and the hospital, and the greatest of these is the hospital. At least this is true so far as mortal life is concerned. The school takes care of a man's early education, the church provides for the future of his soul, but the hospital takes care of him when he has to be taken care of—when he cannot take care of himself.

How vitally essential the hospital is to the life of the community has been brought home to cities and villages throughout the length and breadth of the land by epidemics, such as the "flu," and in only lesser degree is this continually and daily evident. In safeguarding health of the people, and minimizing man's periods of incapacity through illness, directly abetting the activities of commerce and industry—in the actual conservation of life itself, hospitals constantly demonstrate their fundamentally essential character. Repairs are as necessary for human machines as for automobiles. The hospital is the house of conservation for living, working human forces.

The establishment of the first hospital was an historic step in the world's civilization; and communities can still no more usefully and humanely mark their progress than by the promotion of hospitals. There is nothing which so definitely perpetuates one in the grateful consciousness of any city as the organization or expansion of a hospital. No more honored names are found in local annals than those of the hospital builders.

When the need is recognized as very press-



Mary Frances Kern

ing it may be that no one person or group is in a financial position to provide proper hospital facilities. Then such funds are really needed, however, there is usually a way. There is no better way than the Kern way.

Hospital architects know how hospitals should be builded; trained medical men and nurses may know how they should be operated, but it is for people trained in the conduct of fund raising campaigns to know how the funds can be most surely and speedily provided.

Let us help you solve your financial problems. Let us bring years of successful experience in hospital fund-raising to your aid.

The sooner you get started, the sooner you will have the funds in hand. It costs nothing to inquire. Write or telegraph. "THERE IS NO TIME LIKE THE PRESENT TO LAUNCH YOUR CAMPAIGN."

Mary Frances Kern

FINANCIAL CAMPAIGNS

49 Wall Street
New York

1340 Congress Hotel
Chicago, Ill.

17 Adelaide St., W.,
Toronto, Canada

We Raise Money for Hospitals

Within Six Weeks!

Accident Revealed Need of Hospital Facilities in Village

A man and a child injured in an accident Wednesday at Forest avenue and the railroad crossing in Rockville Centre were taken by the police to the Rockville Centre sanitarium. When the police arrived at the institution they learned that there was no room available for the patients and they had to be taken to the Nassau hospital at Mineola.

Officials are of the opinion that occurrences of this sort will impress local residents with the need for a hospital in this vicinity.

The Need Revealed!

An inquiry brought our representative to go over the situation.

As a result of his survey a Hospital Committee was formed and a campaign launched, with \$250,000 as the objective.

Within six weeks the campaign closed oversubscribed by more than \$10,000.

SOUTH SHORE HOSPITAL DRIVE GOES OVER TOP; PLEDGES TOTAL \$260,000

SPECIAL GIFTS WILL PROVIDE FOR EQUIPMENT

George D. A. Combes Praises Loyalty of Workers Throughout Campaign

The Need Met!

Over \$3,075,000 has been raised in recent campaigns through members of our associated organizations. We shall be glad to have you consult us, without any obligation on your part.

HEDRICK, MARTS & LUNDY, INC.
Harriman National Bank Bldg.
527 Fifth Avenue NEW YORK, N. Y.

Members of the Joint Board of Campaign Counsel and Planning

Write for a copy of "Financing Philanthropy"

A group of suburban villages recently faced a very serious situation. Their combined population exceeded 65,000 and yet there were no hospital facilities available within a radius of six miles.

Nor were there any persons of great means who alone could finance such a project.

Texas
The Teachers College Hospital, San Marcos, which has operated for the past five years as a private hospital for students and faculty of the college, under the superintendence of Mrs. L. L. Lusk, will be closed. In the future the Hays County Memorial Hospital will be used in conjunction with the college.

Contracts have been let for the Hamilton Sanitarium, Olney, which is being built by Dr. George V. Hamilton. It is to be a thirty-five bed hospital to be erected at a cost of \$40,000.

The Physicians and Surgeons Corporation plan to erect a 300-bed hospital in San Antonio, at a cost of approximately \$1,000,000.

Virginia

St. Christopher's Hospital, Norfolk, has been discontinued as a hospital and will be operated as a clinic. The medical and surgical cases, it is announced, will be received by the general hospitals of the city.

West Virginia

Dr. George A. MacQueen, owner, Kanawha Valley Hospital, Charleston, has acquired control of the hospital at Keyser, operated by the late Dr. C. S. Hoffman, past-president, West Virginia State Medical Association.

Canada

A new women's hospital is soon to be erected in Montreal, Que., according to a recent announcement of the *Canadian Medical Journal*. The building will be a four-story structure and will be erected at a cost of \$300,000.

The Sisters of Charity of Providence have opened a general hospital in the building formerly known as the Canadian Country Club, Montreal East.

An institution for the chronic insane of Kings County, Nova Scotia, is under construction at Waterville. The building is designed to accommodate sixty patients.

The commissioners of the Soldiers' Memorial Hospital, Middleton, N. S., are planning the erection of a new wing to provide accommodation for maternity cases and an x-ray department.

Newfoundland

The Tuberculosis Hospital and the General Hospital, St. Johns, maintained by the government of Newfoundland, were recently surveyed by T. B. Kidner, New York, and recommendations made for extensive alterations.

Brazil

A 1,800 bed hospital is now under construction by the medical school in Rio de Janeiro which, when completed, will be the largest hospital in South America. The cost of the hospital is being defrayed by a surtax of 5 per cent on all alcoholic beverages. The pediatric section, containing 350 beds, will be opened within the next eight months, according to a recent announcement.

EXTENSIVE COURSES OFFERED IN MEDICAL SOCIAL SERVICE

Eleven courses in social service work are being offered this semester under the joint jurisdiction of the department of medicine and the department of economics and sociology of the University of Indiana, Bloomington. The courses are being taught in Indianapolis and are open to interested adults as well as university students in professional social service training. The courses include environmental medicine and medical social service.

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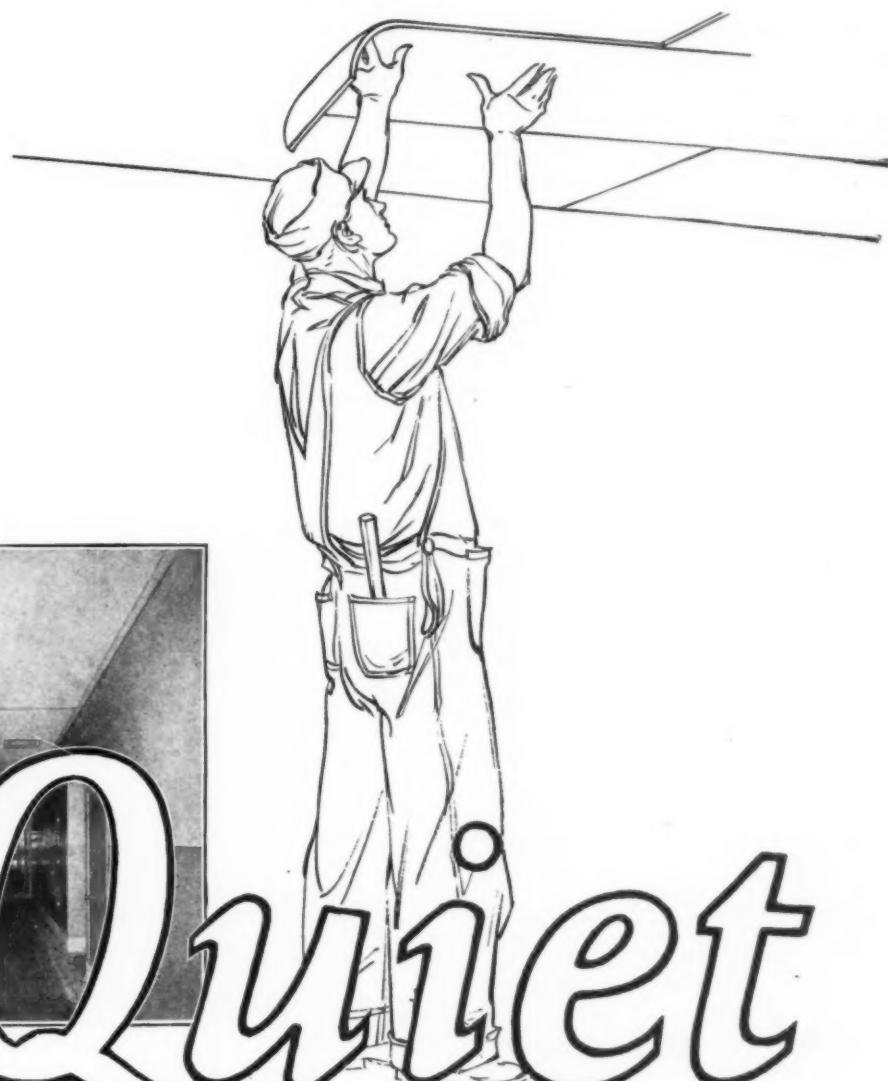
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Corridor Western Reserve Hospital, Cleveland, Ohio. Quieted by Johns-Manville Acoustical Correction.



Quiet for Hospitals — old and new

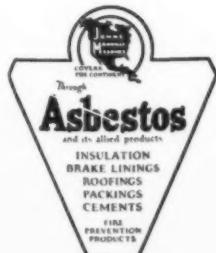
IT is never too late to quiet your hospital with Johns-Manville Acoustical Correction.

If you are interested in new building by all means get in touch with our engineers. They can often suggest slight modifications in plan and specification that subdue noise with least expenditure.

But even if the building is an old one our corrective treatment can be readily applied. Consult us without obligation.

JOHNS-MANVILLE INC., 292 Madison Ave. at 41st St., N. Y. C.
Branches in all large cities

For Canada: Canadian Johns-Manville Co., Ltd., Toronto



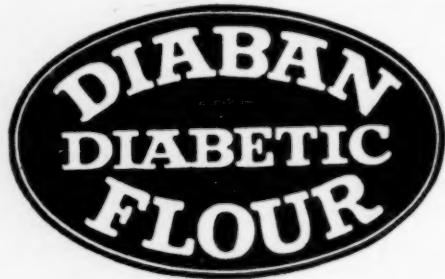
JOHNS-MANVILLE

Acoustical Treatment

Add variety to the

DIABETIC DIET

with appetizing bread and muffins made from



An acceptable bread substitute recognized and accepted by physicians, dietitians and hospitals.

DIABAN Flour is made of wheat, edible nuts, casein, flavoring and leavening, so scientifically blended that 10 grams of Diaban Bread give a value of Pro. 2; Fat 2; Carb. 1.4.

Testing samples and recipes sent, on request, to any hospital.

MacDowell Bros.

OGDENSBURG, N. Y.

BROCKVILLE, ONT. CAN.

MIDWEST FILTERED AIR for the Modern Hospital

BETH ISRAEL HOSPITAL,
New York City



Another
Well Known
Hospital
Equipped with
Midwest
Air Filters

L. A. ABRAHAMSON,
Architect

Beth Israel, of New York City, is another well known hospital in which Midwest Air Filters are reducing cleaning and decorating costs, besides supplying dust-free, practically sterile air for ventilating operating rooms, X-ray rooms, etc.

Ask Dept. MH for certified performance surveys on Midwest installations in service a year or more.

MIDWEST AIR FILTERS
INCORPORATED
BRADFORD, PENNSYLVANIA

OFFICES IN PRINCIPAL CITIES

TWO EUROPEAN SPECIALISTS GUESTS OF TUBERCULOSIS INSTITUTE

The Chicago Tuberculosis Institute was recently host to two eminent European specialists, Dr. Ernst Loewenstein, professor of experimental pathology at the University of Vienna, Austria, and Dr. Edouard Rist, co-director, Laennec Hospital and Dispensary, Paris, France.

These physicians of international fame who rank among the highest tuberculosis authorities in their respective countries, came to America to attend the International Union Against Tuberculosis and the National Tuberculosis Association which met in Washington, in October. During their Chicago visit addresses were delivered by both physicians.

DIRECTORY OF N. Y. TUBERCULOSIS INSTITUTIONS PUBLISHED

A directory and book of information about the tuberculosis institutions serving New York City and the procedure necessary to obtain admission has recently been published by the Tuberculosis Sanatorium Conference of New York. The book is the first of its kind that has been issued since 1915, when the New York Department of Health issued a similar one. Frederic D. Bell, secretary, Hospital Service, New York, is chairman of the committee which compiled the book.

PHYSIOTHERAPISTS SHOULD HAVE PLACE IN ORGANIZATION

Harold R. Conn, M.D., Akron, Ohio, in a recent address given before the annual convention of the American Physiotherapy Association, stated that the physiotherapist's place in a modern hospital organization should be definite and established, her department should not become the resting place of forlorn hopes, or she the rescue crew of operations gone astray. In speaking of the general medical profession in its relation to the field of physiotherapy he said: "The newly organized departments of physiotherapy in many of our old established hospitals have placed remedial measures at the disposal of physicians sadly unacquainted with their virtues and limitations. The cooperation which physiotherapists have offered has not always been reciprocated, not because of lack of willingness, but rather as a result of unfamiliarity and inexperience. Many physiotherapists have pioneered in a sense, and labored under the unfair disadvantage of little or no surgical counsel. They have a right to expect from the attending physician definite instructions as to such treatment as he desires or the alternative of an accurate diagnosis with his explicit permission to use their own judgment as to the therapeutic measures applicable. Nothing can be so demoralizing, so productive of unnecessary failures, or more unscientific than to deny the physiotherapist a working diagnosis and refer the patient with the prescription, 'Physiotherapy, please.'—*The Physiotherapy Review*.

PROVIDING PARKING SPACE

In order to overcome the congestion of automobiles belonging to members of the medical staff parked in front of the administration building of the Alfred Hospital, Melbourne, Australia, a parking shelter to accommodate at least twenty-two cars has been constructed at the rear of the hospital grounds. The shelter is reached by one way traffic and the convenience of the parking facilities thus secured has been acclaimed by the members of the staff.

December, 1926

THE MODERN HOSPITAL

151



Operates By Temperature Only

JOHNSON System of Temperature and Humidity Control includes a thermostat on the wall of each room, which operates each room's radiator independently of all other rooms in the building. The thermostat opens and closes the radiator valve as affected by the room's slightest temperature change from the degree of temperature prescribed for the room. Thus manual attention is relieved and valuably aided: and no possibility of excess heat nor reduced temperature exists. Each room is automatically governed by its own temperature and temperature requirement. And with such constant service accuracy in each room of the hospital a 15 to 35 per cent fuel cost saving also is involved; making the Johnson System a most invaluable essential in every hospital today.

JOHNSON SERVICE COMPANY

Factory & Main Office

MILWAUKEE, WIS., U. S. A.

TWENTY-NINE BRANCHES, UNITED STATES AND CANADA
AUTOMATIC TEMPERATURE REGULATION SINCE 1885

JOHNSON
SYSTEM OF TEMPERATURE AND HUMIDITY CONTROL

The All Metal System: And Designed,
Manufactured, Installed Solely and Entirely
by Johnson Engineers and Mechanics:
Assuring Thoroughly Correct, Reliable Results permanently.



Johnson Dual or Two Temperature Thermostat: one temperature for occupied rooms, another temperature for unoccupied rooms—day or night. Write for details.



ATTRACTIVE and PRACTICAL

THE Kenwood napkin and tray marker offers a dignified and efficient method of marking hospital trays. Besides keeping each patient's tray and napkin properly identified it appeals to the patient's sense of individuality. It occupies but small space, the base being only 2½ inches in diameter. The holder is silver plated on hard white metal, is easily cleaned, and very durable.

Cards are especially printed with the name of your institution as illustrated above, and can be supplied in any colors or assorted colors for special diets if desired.

141A-3—Silver holders, per dozen.....\$5.50

141A-4—Specially printed cards, white only, per 1,000.....\$3.00
Additional thousands, per 1,000.. 2.25

141A-5—Specially printed cards, any color or assorted, per 1,000..... 3.50



SANISORB

the wood pulp cellulose product ideal for use as an absorbent in the making of pads, dressings, etc. Each roll is put up in a strong fibre shipping container, which not only furnishes greater protection but greater convenience in handling and storing.

WILL ROSS, Inc.

457-459 E. WATER ST.

Milwaukee, Wis.

HELP IN ORGANIZING LIBRARIES

Speaking on the therapeutic value of books to patients in the hospital Dr. C. H. Lavinder, U. S. Public Health Service, in a recent address before the Hospital Library Round Table, said:

"A well conducted hospital library service is a therapeutic agent of no mean importance and is so recognized by modern medical men. It is an agency which renders great assistance creating among patients a mental attitude which permits better adjustments to hospital environment and in the creation of a beneficial atmosphere."

Yet many of our hospitals today, in the face of increased costs, burdened facilities and staff, problems of administration and operation have found but little time to devote to the building up of a patient library. This work has, in most cases, been left to other hands, such as the social service worker, and to the unguided generosity of a general public which in large part believes the hospital a welcome repository for old, unused and unwanted books.

But, on the whole the individual who is a patient in our hospitals is an average citizen who for a short time is incapacitated. He reads just as good books and magazines as any one else. His tastes, knowledge and intelligence do not suddenly alter when he enters a hospital door.

Many hospitals, however, are today dependent upon these two agencies for their supply of books. There is, it seems, a need both for the establishment of patient libraries as an integral part of the hospital's service, and for the development and betterment of patient libraries in those hospitals where they are already established. And, certainly, on the part of the general public there is needed a wider, more general knowledge about the value of books in hospitals and the type of books which hospitals can use.

To acquaint the general public with these facts, and to assist in the establishment and development of hospital libraries, is a part of the program of adult education which has been begun by the American Library Association, which has inaugurated a general program of education concerning the hospital library. Its nation-wide experience and resources in the founding, operating and development of libraries and its extensive library service in army and navy hospitals during the war, is now available to all hospitals desiring help in this work.—*International Journal of Medicine and Surgery*.

APPLYING PREVENTIVE MEDICINE TO THE PRACTITIONER

The local hospital is the natural health center of a community, and the natural center from which health examinations may be promoted.

Submitting to an examination himself is one of the most efficient of all means of arousing the interest of the doctor and stimulating his desire to acquire knowledge. Putting himself in the patient's place, literally and completely, will be his best training in methods of dealing with his patients. Moreover, it will prove his sincerity in what he urges his health client to do.—Earl H. King, M.D., in the *New York State Journal of Medicine*.

HOSPITAL HAS BROADCASTING STATION

The new Rosedale Hospital, Minneapolis, Minn., has a broadcasting station and entertainment programs arranged primarily for the patients at the hospital are broadcast every night so that they may be shared with outsiders who in that way become acquainted with the hospital and its good work.



*Always look for
the name on the
bottle cap to be
sure of the original.*

To make your Christmas celebration the greatest ever

WITH Christmas day approaching, you are probably busy with the plans of a celebration for your patients, a celebration built around the Christmas dinner. A dinner that, of necessity, must only consist of foods and beverages that are perfectly safe for your patients.

What might you find that could better express the jollity and gaiety of the season than "Canada Dry." All the patients will welcome it. For the sheer joy and companionship of a well-loved

friend gleams through its mellow, piquant flavor.

Physicians and dieticians know that "Canada Dry" is a safe drink. Pure Jamaica ginger—constant laboratory tests to insure its purity—a beverage that is carefully guarded in all the stages of its manufacture. That is why it is served in the leading hospitals of the United States and Canada, and why physicians everywhere prescribe it for their patients and use it in their homes.

"CANADA DRY"

Does not contain capsicum

Reg. U. S. Pat. Off.

*Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated,
25 West 43rd Street, New York, N. Y. In Canada, J. J. McLaughlin Limited. Established 1890*

NOVOCAIN
PYRAMIDON
HOLOCAIN

SUPRARENIN
ORTHOFORM
ANAESTHESINE

Dependability in medicinals

. . . can be evaluated only in the course of time. A few favorable clinic results can not be accepted as determining the therapeutic value of a product. Many and reliable reports of experiences, duplicated and reduplicated, are essential to bespeak for a drug the continuous approval of the profession.

Metz-Made Medicinals, manufactured with conscientious care, are time-tried and tested. There may be "similar" products—but there is one outstanding attribute most reassuring to the user that is inherent in Metz-Made Medicinals: their production in strict conformity with the postulates and the processes of their originators and their proved value.



SALVARSAN
SILVER-SALVARSAN

NEOSALVARSAN
SULPHARSPHENAMINE-METZ

The Wilson Rubber Company



Manufacturing

SURGEONS' GLOVES

In a complete line of weights and sizes in either banded or rolled wrist construction.

All of known high quality and rendering the most economical service.

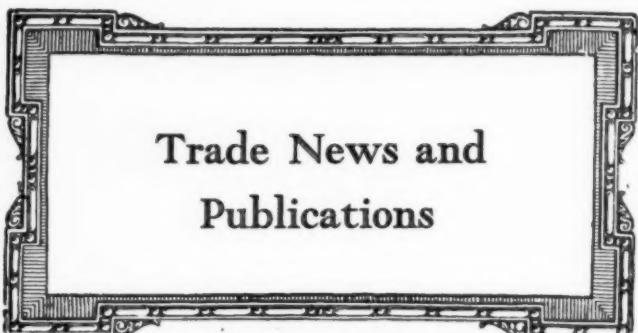
Also

Finger Cots—Examination Cots—Obstetrical Gloves—Autopsy Gloves—Drainage Tubing—Dilator Covers—Acid and Industrial Gloves—Household Gloves, Electricians' Gloves.

Selling Through the Jobber

THE WILSON RUBBER COMPANY
CANTON, OHIO

Largest Exclusive Glove Manufacturers in the World



Petrolagar.—The Deshell Laboratories, Inc., Chicago, have recently mailed to the trade a four-page folder describing their product, Petrolagar. The folder emphasizes the fact that this emulsified oil is a better lubricant and has more of a permeating effect than do plain oils.

Automatic Refrigeration.—General Refrigeration Co., Beloit, Wis., has issued a six-page folder describing the Lipman line of refrigerators of the automatic type. It shows the feasibility of using this refrigerator in small as well as in large construction, and describes its ability for heavy duty work of many varieties.

Laundry Equipment.—The Troy Laundry Machinery Co., Ltd., Chicago, has published a series of descriptive folders showing the various units that it manufacturers. The Troy extractor (direct motor drive), the big eight flatwork ironer, the Premier drying tumbler, the Troy drying tumbler (type "A" motor drive), the 30-inch Troy Premier washer (monel cylinder, monel shell, type "B" motor drive), the 30-inch Troy Premier washer (monel cylinder, monel shell, belt drive), the Troy Premier washer (belt drive), and the Troy Premier washer (type "A" motor drive), are the units that comprise the series. Detailed specifications and full descriptions are given in each case.

Shadowless Operating Lights.—The B. B. T. Corporation of America, Philadelphia, has sent out a new folder describing its no shadow lighting system. After the principle of the system is explained and the description of the construction is given the various types of Scialytic lights are taken up and discussed. The folder is illustrated by drawings and photographs of actual installations.

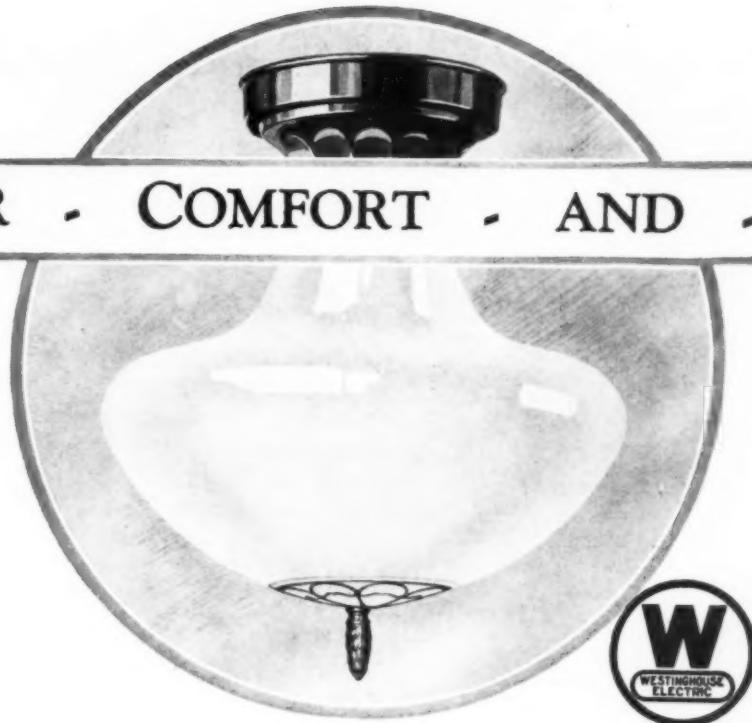
Nurses Collars and Cuffs.—The E. W. Marvin Company, Troy, N. Y., is circularizing the hospital field with a descriptive folder of its newest collars and cuffs for nurses and other personnel of the hospital. The folder is illustrated by drawings of the cuffs and collars and the last page is devoted to the gowns, aprons, bibs, binders and other similar lines used in the hospital.

Heating Pads.—The Kny-Scheerer Corporation of America, New York, has mailed out a small folder advertising its Varick heating pad. The special features of this product together with price lists are shown.

Digitan—Merck & Co., New York, have issued a treatise on digitan, which they call "a physiologically standardized preparation of digitalis." The booklet shows the various uses for this drug and compares it with other similar preparations.

Dishwashers.—The Crescent Washing Machine Co., New Rochelle, N. Y., has just mailed out two descriptive booklets showing the four high speed models and the three automatic models of washers that this company makes. All models are illustrated and described and the principles involved are also clearly described.

FOR - COMFORT - AND - CLEANLINESS



In Hospitals

THE need for glareless light is greatest where rest and comfort combat pain and anxiety. Sol-Lux luminaires give that kind of light, ample for the details of hospital work, yet soft and restful to the eyes. The special diffusing glass takes the glare from the lamp without absorbing a high percentage of its light.

Cleanliness, another requisite of hospital installation, is effected in Sol-Lux by the method of supporting the globe. A keeper-ring holds the globe against the husk, making it totally enclosed and preventing the collection of dust and bugs in the bottom of the globe.

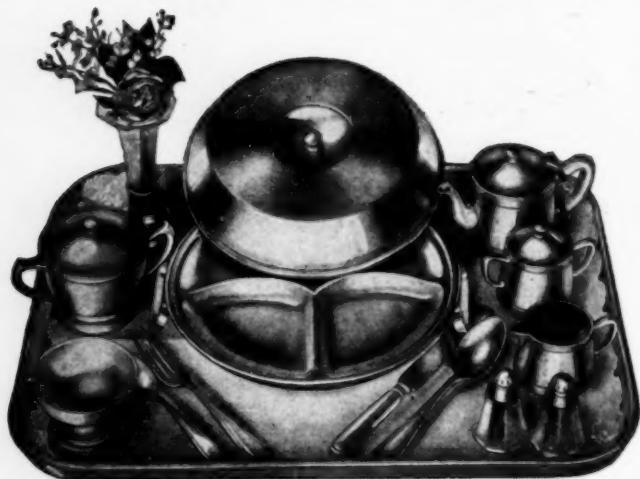
Sol-Lux luminaires are made in ceiling and suspension types, for either low or high ceilings. Catalog 47-B gives complete information about them. Write for it.

Westinghouse Electric & Manufacturing Company
Merchandising Department South Bend, Indiana

Westinghouse

X90173

THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Individual Bud Vase, Salt and Pepper Shakers, and Superior Grade Sectional Plate Flatware.

*Serve Your
Christmas Dinner
from This Silver Service*

THORNER BROTHERS

*Importers and Manufacturers of
Hospital and Surgical Supplies*
386-390 Second Avenue
NEW YORK CITY

Sheeting, Sheets and Pillow Cases.—Naumkeag Steam Cotton Co., Salem, Mass., is sending out to hospitals a small booklet containing samples of the materials with which its products are made. The booklet is unique and gives the superintendent a basis for comparison with other goods as well as impresses him with the quality that is used in the finished product.

Centrifugal Pumps.—The Young Pump Company, Chicago, has published a bulletin showing the Young centrifugal vacuum and boiler feed pump. Diagrams, drawings, charts and specifications illustrate the text which is of a descriptive nature.

Silverware.—The International Silver Co., Meriden, Conn., has just printed an attractive folder which is mostly illustrations of hospital and institutional silverware. The facing pages of this four-page folder show the designs that have been especially made for hospitals.

Betz Company Moves Headquarters.—The Frank S. Betz Company, New York, well-known manufacturers of hospital and surgical supplies, has moved its headquarters to 348-352 West Thirty-fourth St., New York.

New Quartz Glass.—The Vitaglass Corporation, New York, has recently issued a four-page folder describing the qualities of Vitaglass, a new quartz glass for transmitting the actinic rays of the sun. The folder deals with heliotherapy, ultra-violet light, application and the forms of Vitaglass. There is also included in the folder a reprint of an article on Vitaglass by Dr. J. Bell Ferguson.

Horlick's Malted Milk.—Horlick's Malted Milk Corporation, Racine, Wis., recently distributed an envelope containing special formulae for infants and recipes for using malted milk, on ready reference cards.

Finnel System, Inc.—Finnel System, Inc., formerly the American Scrubbing Equipment Company, Hannibal, Mo., has recently distributed folders dealing with the Finnell scrubber, waxer and polisher and a new mop truck for industrial and institutional use.

The Fosco Line.—F. O. Schoedinger, successor to the Columbus Aseptic Furniture Co., Columbus, Ohio., has lately prepared a twenty-four page catalogue, describing several of its aseptic metal hospital and surgical furniture items. Included in the pages are descriptions of operating tables, visible clinical chart filing system, chart desks and racks, delivery beds, combination bedside tables, dressing tables and tray carriages and racks.

Cream of Wheat.—Cream of Wheat Company, Minneapolis, Minn., has recently issued two catalogues suggesting uses for Cream of Wheat in the home and for feeding children. Fifty recipes using Cream of Wheat as an ingredient are included in "Fifty Ways of Serving Cream of Wheat," while "The Important Business of Feeding Children" outlines the practical dietetic and educational treatment of the pre-school years.

Henrici Laundry Machinery.—The Henrici Laundry Machinery Co., Boston, has prepared a folder outlining the heat-retaining qualities of metal washers for laundries, arrived at following a series of four tests of wooden and metal washers.

Sponges and Dressing Pads.—A folder dealing with Zobec Sponges and New Era Dressing Pads, manufactured by Johnson & Johnson, New Brunswick, N. J., has recently been received.

Wear-Ever Aluminum Cooking Utensils.—The Aluminum Cooking Utensil Co., New Kensington, Pa., manufacturers of Wear-Ever aluminum ware, has recently prepared a folder dealing with semi-heavy stock pots, and shallow and deep sauce pans for use in institutional kitchens.

December, 1926

THE MODERN HOSPITAL

157

A T L A S T!

YOU CAN WRITE ON THE GLASS!

Adhesive tape around the bottle makes a crude and unsatisfactory writing surface.

The new way is to write directly on the glass—and it's as easy as writing on paper.

When the nurser is cleaned, the writing washes off the frosted panel—ready for next time.

Clean, convenient, legible—no wonder hospitals like it.



The wide mouth of the Hygeia food-cell makes cleaning and filling easy.



The Hygeia Breast-nipple is smooth, inside as well as out. You can turn it inside out. Every part of it can be thoroughly cleaned.

Hospitals supplied FREE

We will send as many of this new hospital-size Hygeia Nurser as your hospital can use. No charge. No conditions attached, except that they will be used in your own hospital, not redistributed.

The term "Nurser" as used here includes the glass food-cell, breast-nipple and rubber cover—complete.

Use the coupon below—or write us.

Hygeia

THE SAFE NURSING BOTTLE



This rubber cover "corks" the Food-cell until feeding time.

HYGEIA NURSING BOTTLE COMPANY, INC.
1208 MAIN STREET BUFFALO, N. Y.

For complete index of advertisements refer to the Classified Directory

Hygeia Nursing Bottle Co., Inc.,
Buffalo, N. Y.

Please send us FREE OF CHARGE and delivered at our door without cost to us dozen Hospital-size Hygeia Nursers complete.

Name of hospital

Address

City..... State.....

Signed by

Macbeth Daylighting For Operating and Labor Rooms

The color quality of daylight has particular and important advantages over ordinary artificial light. Under daylight skin and flesh colors are always seen naturally, quickly and without effort or uncertainty.

Macbeth Daylighting is a satisfying visual reproduction of good natural daylight produced with standard clear glass incandescent lamps and accurate colored glass filters.

Now in use over ten years, approved and used by thousands of color experts in widely different fields where "seeing as in daylight" is important.

A carefully engineered lighting system, adapted to the location.

Macbeth Daylighting Company, Inc.

Manufacturers of equipment for the scientific reproduction of daylight

235 West 17th Street

NEW YORK

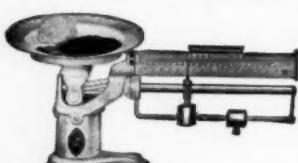
SCALES

FOR HOSPITAL AND INDIVIDUAL USE



No. L2. Price \$5.00

No. 2D Dietetic Computing Scale Capacity 500 grams by 2 grams, also 16 ounces by $\frac{1}{4}$ ounce. The sliding computing beam shows portions and totals at one operation. Weighs each item of food in prescription without deduction for tare weight. Beautifully finished in white enamel. Size $7\frac{1}{4} \times 15\frac{1}{4} \times 7\frac{1}{2}$. Weight boxed, 13 lbs. Very sensitive and accurate. Price....\$18.00



No. 2D. Price \$18.00



No. 32S. Price \$21.50

If your dealer hasn't these scales he will order for you. If not order direct.

No. 32S is a very superior Infant Scale with double beam. Capacity 32 lbs. by $\frac{1}{4}$ oz. graduations. Beautifully finished in white enamel, large brass scoop. Bearings and pivots are made of highly tempered steel. Guaranteed superior to any other Infant Scale. Very sensitive and accurate. Price....\$21.50

PELOUZE MANUFACTURING CO.

232 E. Ohio Street, Chicago

Uniforms.—Mandel Brothers, Chicago, have recently sent out a series of booklets on uniforms and professional wearing apparel. The catalogue illustrates the many items that are used in the hospital and are sold by this company. Laboratory coats, aprons, gowns, caps, smocks, convalescents' robes, uniforms and caps for nurses and other garments are shown.

Dessert Recipes.—The Junket Folks, Little Falls, N. Y., are sending out many recipes in a little booklet that is issued by their domestic science department. Each recipe is complete and the various steps in preparing the foods are illustrated. It has definite value to dietitians and superintendents of all hospitals.

Hospital Dolls.—M. J. Chase, Pawtucket, R. I., has issued a new book on the Chase Hospital Doll. Several types of dolls are shown and described in the book and the price list is contained on an insert. An interesting little story on how the Chase dolls are made is also to be found.

Hostess Book.—Canada Dry Ginger Ale, Inc., New York, has prepared a most unique "Add-A-Leaf" hostess book that contains recipes, menus, etiquette and entertainment. It contains many recipes that can be used by dietitians and is bound in leather, making it convenient for the dietitian to handle and carry as a note book during her rounds of duty.

Linen Marking Devices.—J. & J. Cash, South Norwalk, Conn., has issued a new booklet of stiff cardboard pages upon which are shown their many designs of woven names. It is called their style book and on the first cover-page are some actual woven name samples showing sixteen ways of using the strips. Prices are also contained in the booklet.

Physiotherapy and Diathermy.—H. G. Fischer & Co., Chicago, have recently sent out to hospital superintendents four books on various phases of physiotherapy, diathermy and allied subjects. The four books are titled "Diathermy Theory and Practice," "Thirty Leading Articles on Physiotherapy," "Diathermy Therapy," and "Physiotherapeutic Lectures." The subjects are well covered in each case and are most valuable to superintendents, physicians, nurses and physiotherapy technicians.

Lighting Fixtures.—The Westinghouse Electric & Manufacturing Co., George Cutter Works, South Bend, Ind., has issued catalog 47-B, entitled "Sol-Lux" Lighting. Many lighting fixtures and units with instructions and diagram drawings give value to the booklet. There are also specifications and one chapter given to how to plan a lighting system.

Ambulances.—The Studebaker Corporation of America, South Bend, Ind., has a new catalogue on funeral cars and ambulances which contains many illustrations of its new ambulances showing both the exterior and interior of these cars. These cars are both beautiful and practical and are designed to the latest needs of hospitals. Full mechanical specifications are also included in this catalogue.

Hospital Furniture.—The Stickley Brothers Co., Grand Rapids, Mich., has issued a new catalogue showing their new models in hospital and nurses' homes furniture. Fourteen pages of illustrations show the various units used in the hospitals and homes of the country.

Elevators.—Kimball Brothers Co., Council Bluff, Ia., has mailed out to hospital executives its latest catalogue on electric elevators and dumb-waiters. The booklet contains points to consider in the selection of elevators, with many illustrations of the machinery and mode of operation together with diagram drawing and cross-section



**Increased Service to
the Institution**

Privacy to the Patient— corridor noises cut off; toilet facilities in ready access; varied arrangement of doors makes handling of visitors simple.

Safeguards Convalescence— quietness decreases use of narcotics; eliminates cross infection because of individual unit equipment and sterilization utilities; fire safe.

Speeds Up Service— cuts down walking of nurses and increases efficiency 30 per cent; brings all patients relatively closer to nursing center and shortens corridors.

Simonson Standardized Steel Utility Rooms* for Hospitals

This equipment, originally designed for the new unit of the Presbyterian Hospital, Chicago (Bacon Plan Unit), is now available for general use throughout the entire hospital field. Its employment in hospital design and construction insures the maximum of efficient service at low cost. In all contemplated construction programs the possibilities of the Bacon Plan Unit Standardized Steel Equipment should be investigated.

Roger A. Simonson & Co., Chicago
Dear Sirs: It was a pleasure to me to sign your contract to do the metal construction work in our new addition which includes thirty-five Bacon Plan rooms. It is only reasonable that you should have the contract, for, during the fifteen years that you have been doing work for the Hospital, you have always given the Presbyterian a square deal.
I hope that our business relations may continue for many years to come. Very truly yours,
ASA BACON, Superintendent.
Presbyterian Hospital of Chicago.



**Practical Economy
in Construction**

Reduces Building Cost— simplifies plumbing; speeds up construction; the units are made up of sheet steel and fabricated to be set in place when structural frame is under construction.

Decreases Cubic Contents— compactness of construction utilizes every available cubic foot of space; reduces maintenance costs and time expended for service by nurses and employees.

**Increases Percentage of
Occupancy—** the similarity of facilities for every type of case guarantees absolute utility because patient can be isolated, if desired.

Roger A. Simonson & Co.
122 S. Michigan Ave. CHICAGO

*Steel Utility Rooms for Hospitals and Institutions are fully protected by U.S. Letters Patent No. 1,609,017

Tycos APPARATUS for the CARDIO-RESPIRATORY TEST

As developed by Dr. Harold M. Frost, Assistant Medical Director, New England Mutual Life Insurance Company, Boston.

The Cardio-Respiratory Test was developed some time ago, and with the improved instruments developed by the Taylor Instrument Companies, bids fair to become one of the most valuable procedures available for both the specialist and general practitioner.

The purpose of the Test is to determine the functional capacity of the heart by increasing its load. This is accomplished by securing variations in the intrathoracic pressure thus compressing the vena cava and pulmonary vessels.

The instruments used are the Tycos Spirometer and Manometer (shown above) in conjunction with the Tycos Sphygmomanometer. These instruments are for sale at medical supply houses.



WRITE FOR BULLETIN ON THE CARDIO-RESPIRATORY TEST TO THE MEDICAL DEPARTMENT OF

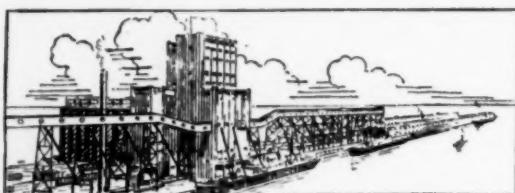
Taylor Instrument Companies

ROCHESTER, N. Y., U. S. A.

CANADIAN PLANT
TYCOS BUILDING
TORONTO

MANUFACTURING DISTRIBUTORS
IN GREAT BRITAIN
SHORT & MASON, LTD., LONDON

(See America First" Series No. 48)



This Municipal Grain Elevator recently erected at Norfolk, Va., completes an already perfect harbor, and embodies the latest ideas in Elevator construction.

Embodying the best ideas in dishwashing the

FEARLESS DISHWASHER SYSTEM

is in operation in twelve (12) Hospitals in and around Norfolk because it keeps their dishes thoroughly clean and strictly sanitary, therefore free from germ infection.

There are so many points of superiority about the FEARLESS you should write us, or ask your Supply House about our "Hospital Special" Machine.

FEARLESS DISHWASHER CO., Inc.

"Pioneers in the Business"

Factory and Main Office:

175-179A Colvin Street

Rochester, N. Y.
U. S. A.

Branches at New York and San Francisco



In cases where it is undesirable to resort to medication as a relief from constipation, the simple inclusion of the New Pettijohn's whole wheat cereal as a regular part of the diet frequently proves entirely effective.

The Quaker Oats Company
CHICAGO, U.S.A.

The New Pettijohn's

WHOLE WHEAT CEREAL

views. The catalogue is most attractive and of definite value to building committees.

Bedsteads and Mattresses.—Richardson Wright & Co., Boston, Mass., have published Catalogue No. 10 describing its line of aseptic steel hospital furniture, bedsteads, mattresses and pillows. Besides its beds and mattresses are also shown steel carts, racks, screens, cabinets and other products of this company.

Enameled Wares.—The Vollrath Co., Sheboygan, Wis., has issued Catalogue No. 5 in which its full line of Vollrath ware is shown and described. The catalogue is handy for filing and will make a valuable addition to the superintendent's collection of catalogues.

Shower Baths and Stalls.—The Hoffmann & Billings Manufacturing Co., Milwaukee, Wis., has mailed out its Bulletin No. 220 N.A. which contains many illustrations of its shower bath installations as well as pictures of parts and accessories. The shower is known as "Niedecken," and descriptions with measurements of the showers and stalls are also to be found therein.

Microscopes.—The Spencer Lens Co., Buffalo, N. Y., is sending out a series of folders describing its several microscopes and other laboratory apparatus. These folders are convenient for filing and contain much interesting data for the superintendent and the pathologist.

Automatic Water Stills.—The Precision Scientific Co., Chicago, maker of laboratory equipment, has issued several descriptive booklets showing the Precision automatic water still, electrical specialties for the laboratory and staining dishes. Diagrams showing the method of operation and specifications are given in most cases.

Food Carts and Diet Boxes.—The Swartzbaugh Manufacturing Co., Toledo, Ohio, has mailed out its catalogue showing food carts and diet boxes and describing the method used in retaining the heat without artificial means. The booklet also contains the results of several "heat holding" tests recently made.

Ranges.—The Standard Gas Equipment Corporation, New York, has issued a booklet that is entitled "Cutting Cooking Costs" and in which is described its line of kitchen ranges both singly and in batteries. Blue prints of installations and illustrations of the ranges are also to be found here.

Foods and Beverages.—John Sexton & Co., Chicago, have recently issued a price list and catalogue of their lines of teas, coffees, cocoas, preserves, jellies, minced meats, baking powders, spices, flavoring extracts, toilet soaps, floor waxes and canned goods showing the company's method of shipping to zones in the United States. All goods are listed, described, illustrated and priced.

Weaving Materials.—The Shuttle-Craft Co., Inc., Cambridge, Mass., has mailed out an artistic booklet in which are contained instructions in weaving and descriptions of its weaving machines that are used by occupational therapists in hospitals. Inasmuch as occupational therapy is now universally accepted by hospitals in the United States and Canada, superintendents will be much interested in this literature.

Water Coolers and Pails.—Cordley & Hayes, New York, have issued several catalogues and price lists to hospital superintendents in all parts of the country. Descriptive matter pertaining to their products is shown and priced. Several of their new products are also described in the catalogues and leaflets that have been issued.

Lighting Fixtures.—The Crouse-Hinds Co., Syracuse, N. Y., has published a broadside in which are described its vapor-proof condulets. These are in several types, each described by illustrations and text.

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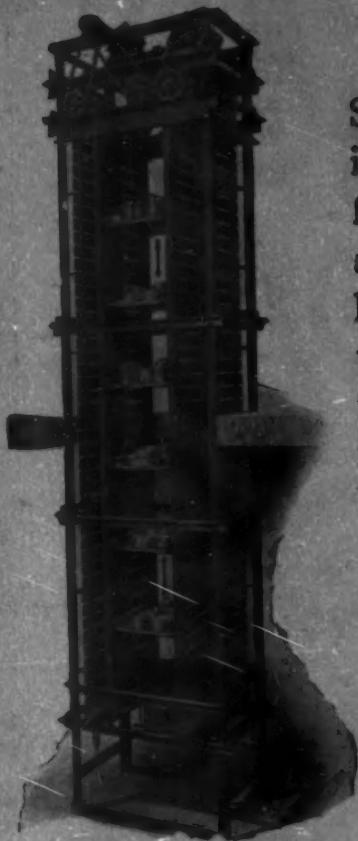
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SUBVEYORS

SOLVE FOOD AND
DISH HANDLING PROBLEMS

FOOD SERVICE



Model "F" Subveyor

Subveyors will elevate food either on trays or in containers continuously to any number of floors. Visualize the economies resulting from an installation in your institution. There are hundreds of Subveyors in operation throughout the entire country which are daily demonstrating the economy and efficiency of this equipment. Model "F" Subveyor illustrated to the left is the model for Food Service. Complete catalog and interesting Food Service Survey are yours for the asking.

CENTRALIZED DISH WASHING DEPARTMENTS



Dishwashing departments of hospitals should be centralized in one department for the following reasons:

- (1) Reduce your investment in unnecessary equipment.
- (2) Confine noises and odors incident to dish washing departments to an isolated location.
- (3) Have absolute control of dishwashing crew.
- (4) Have more room for patients.
- (5) Reduce china breakage (more than 50 per cent).

The Model "A" Subveyor illustrated to the right will carry trays of soiled dishes from any number of floors to the centralized dishwashing department. Trays are discharged automatically from vertical to horizontal section which in turn discharges trays upon scrapping table. Complete detailed information on centralized dishwashing departments will be sent on request.

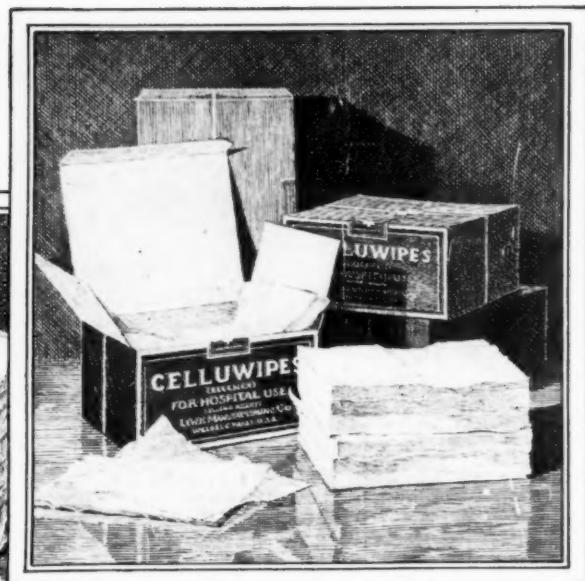
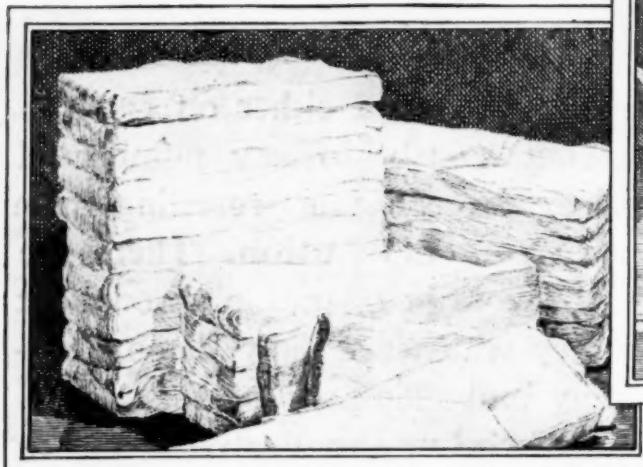
SAMUEL OLSON & CO.
2418 Bloomingdale Ave.
CHICAGO

Consolidated Bldg.
Los Angeles

Fifth Ave. Bldg.
New York

Model "A" Subveyor

To these products



KOTEX AND CELLUWIPES—two finished products of bulk Cellucotton

Cellucotton gives greater usefulness ABSORBENT WADDING —and hospitals find them equally indispensable

GREATER effectiveness—at lower cost—has made Cellucotton known as the most useful of all absorbents. Now, all its super-absorbency—all its greater economy, can be found in two Cellucotton products—Kotex and Celluwipes.

All the superior qualities of Cellucotton—and more! For these finished products also offer distinct, unique features of their own. Kotex pads, for instance, come ready-made—of Cellucotton wrapped in pure, fine Curity Gauze. Gone is the waste of time, of material, which hospitals inevitably suffer in the making of finished pads.

Patients find Kotex comfortable—nurses find it thoroughly absorbent, with an unusual ability to retain drainage. There are two sizes—ordinary thickness for average needs, and super-size for special thickness requirements.

To perfect their efficiency as wiping material, Celluwipes are specially calendered. Their necessary, uniform firmness results from that process—which is so devised that none of Cellucotton's super-absorbency is lost. Softer and much more absorbent than paper, Celluwipes are also more economical than most materials now in use. Made from single layers of Cellucotton, cut 6 x 5 inches, they are remarkably easy to use.

To hospital executives who wish to try either of these products—or bulk Cellucotton—we shall gladly send generous samples. Experiment with them in your own dressings room.

Why is Cellucotton the most useful absorbent?

- because it absorbs from 4 to 8 times more drainage before saturation than most grades of absorbent cotton.
- because it retains more liquid before leakage takes place.
- because it absorbs 3 to 5 times as fast as absorbent cotton.
- because it draws fluid against gravity. It serves as a wick instead of a dam.
- because fluid penetrates to every part of the Cellucotton dressing.
- on account of its bulk, it makes more dressing per pound than absorbent cotton.
- because it is lighter, and more comfortable for the patient.
- because its cost is so low as to make it one of the most economical forms of absorbents.

NOTE: Cellucotton's success has naturally been followed by substitutes. So, when buying, insist on genuine Cellucotton. It comes wrapped in blue, easily-identified paper, stamped with the trade-marked name "Cellucotton".

LEWIS MANUFACTURING COMPANY
(Div. of Kendall Mills, Inc.) W ALPOLE, MASS.

LEWIS MANUFACTURING CO.
OF CANADA, LTD.
13 Victoria Square Montreal, Quebec

ALWAYS INSIST ON GENUINE CELLUCOTTON (Absorbent Wadding)

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